SCOTT ROSEMAN, Ph.D. CONSULTING PSYCHOLOGIST
INTAKE INFORMATION

Date;_____ ***PLEASE PRINT LEGIBLY***

Person completing this form :_____ DOB_____ Age:_____ SS#_____

Patient: (if different)_____ Date of Birth_____ Age:_____ SS#_____

School/Grade (if patient is a minor) or Occupation: _____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone: ( )_____ Work Phone: ( )_____ Mobile Phone: ( )_____

Contact Email Address: _____

Occupation:_____ Employer: _____

Marital Status; ___Single ___Married ___Separated ___Divorced ___Widowed

Name of Spouse_____ Date of Birth_____ Age_____

Occupation:_____ Employer: _____

Home Phone: ( )_____ Work Phone: ( )_____ SS#_____

Child's Other Parent (if different from above)_____ DOB_____ Age:____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone: ( )_____ Work Phone: ( )_____ SS#_____

Occupation:_____ Employer: _____

Children in the family (Do not include the patient)

Name_____ DOB___/___/___ Age_____ School/Grade/Occupation _____

Name_____ DOB___/___/___ Age_____ School/Grade/Occupation_____

Name_____ DOB___/___/___ Age_____ School/Grade/Occupation_____

Name_____ DOB___/___/___ Age_____ School/Grade/Occupation_____

Person Responsible for Payment:_____ Referred By:_____

Name of Person who is the primary insured:_____ Relation to patient: _____

Insurance Company_____ ID#_____

Initial Authorization #_____ # of Visits_____ Co-pay Amount _____

Contact Telephone # for Insurance Company_____

******No less than 24 hour notice must be provided in the event that an appointment needs to be canceled. Failure to provide such notification will result in the assessment of a $100 Fee. Insurance cannot be billed for a no show or cancellation******

Please remember that insurance is considered a method of reimbursing the patient for fees to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay the deductible amount, co-insurance, or any balance not paid by your insurance. In an effort to keep fees to a minimum, full payment or approved co-payment is required at the time of each appointment. I understand that in the event this account is assigned to an agency or attorney for collection and/or suit, I am responsible for reasonable attorney's fees, costs of collection, and court costs.

Signed_____ Date:_____

Background Information

Patient Name:_____ Sex:_____ Age:_____

Reason for seeking Treatment at this time:

_____

_____

_____

Are you currently under the care of a psychiatrist ___ Yes ___ No

If yes, please provide name and contact information:

_____

_____

Please provide name(s) of any current or prior therapists and dates seen:

_____

_____

Previous Psychiatric Hospitalizations?_____

Are you currently being treated for any health problems? ___ Yes ___ No

If yes, please list _____

_____

_____

Current Medications and Dosage:_____

_____

_____

Medications you have taken in the past:_____

_____

_____

Do you now, or have you ever in the past used alcohol, prescription drugs or illegal substances to excess?
___ Yes ___ No

If yes, please provide details:_____

_____

_____

I attest that this information is correct to the best of my knowledge:

Signature:_____ Date:_____

SCOTT ROSEMAN, Ph.D.

CONSULTING PSYCHOLOGIST
FLORIDA LICENSE PY0003306

2499 GLADES ROAD • SUITE 114
BOCA RATON, FLORIDA 33431
Telephone: (561) 869-3311
Fax: (877) 868-7602

Consent for Treatment

This form is to document that I,_____, give my permission and consent to Scott Roseman, Ph.D. to provide psychotherapeutic treatment and/or psychological assessment to me and/or _____, who is/are my spouse/child/children.

While I expect benefits from this treatment I fully understand that because of the factors beyond our control or other factors, such benefits and particular outcomes cannot be guaranteed.

I understand that because of the counseling or therapy I/he/she/we may experience emotional strains, feel worse during treatment, and make life changes which could be distressing.

I understand that this therapist is not providing an emergency service and that I have been informed of whom to call upon in an emergency or during weekend and evening hours.

I understand that regular attendance of scheduled sessions will produce the maximum benefits but that I or we are free to discontinue treatment at any time. If I decide to do so I will notify Dr. Roseman at least two weeks in advance so that effective planning for continued care can be implemented.

I understand that conversations with Dr. Roseman will almost always be confidential. I further understand that all therapists, by law, must report actual or suspected child or elder abuse or domestic violence to the appropriate authorities. In addition all therapists have a legal responsibility to protect anyone I/he/she /we may threaten with violence, harmful or dangerous acts (including those to myself) and may break the confidentiality of our communications if such a situation arises. I understand that Dr. Roseman will make reasonable efforts to resolve these situations before breaking confidentiality.

I understand that I am financially responsible for this treatment/assessment and for any portion of the fees not reimbursed or covered by my health insurance or managed care plan. I further understand that if my care is being governed by an insurance or managed care plan that this entity will be entitled to review my ongoing treatment plan and have input into my plan of care so long I participate in this managed care plan.

I understand that I, or my legal representatives have the right to access my medical record with notification of at least 48 hours. I understand that I may not make any changes to the record, however I may add information to the record for the purposes of clarification.

I know of no reasons I/he/she/we should not undertake this therapy and I/he/she/we agree to participate fully and voluntarily.

Signature:_____ Date___/___/___
(of client or a person authorized to consent for client)

Print Name:_____

NOTICE OF PRIVACY PRACTICES OF
Scott Roseman, Ph.D.

2499 Glades Road Suite 114 Boca Raton, Florida 33431 Tel: (561)869-3311 Fax: (877) 868-7602

This notice, effective as of April 14, 2003, describes how mental health information about you may be used & disclosed & how you can get access to this information

PLEASE REVIEW THIS DOCUMENT CAREFULLY

1. PURPOSE: Dr. Roseman & his professional staff follow the privacy practices described in this Notice. Your mental health information will be kept in records that will be maintained and protected in a confidential manner, as required by law. Please note that in order to provide you with the best possible care & treatment, all staff involved in your treatment and employees involved in the health care operations of my office may have access to your records.

2. WHAT ARE TREATMENTS & HEALTH CARE OPERATIONS?
Your treatment includes sharing information between mental health care providers who are involved in your treatment. For example, if you are seeing a physician, a psychiatrist & a psychotherapist, they may share information in the process of coordinating your care. Treatment records may be reviewed as part of an on-going process directed toward assuring the quality of the psychotherapy practice.

3. HOW WILL DR. ROSEMAN'S PRACTICE USE PROTECTED HEALTH INFORMATION?
Dr. Roseman will retain your personal mental health record for approximately 7 years after your last clinical contact. After that, the record will be shredded or burned or otherwise destroyed in a way that protects your privacy.
Until the records are destroyed, they may be used, unless you ask for restrictions on a specific use or disclosure, for the following purposes:

+ Appointment reminders
+ Notification when an appointment is cancelled or rescheduled.
+ As may be required by law.
+ For public health purposes such as reporting of child or elder abuse or neglect: reporting reactions to medications; notifying authorities of suspected abuse, neglect, or domestic violence as required by the law.
+ Mental Health oversight activities such as audits, inspections or investigations.
+ Lawsuits & disputes. (I will attempt to provide you advance notice of subpoenas before disclosing information from your records.)
+ Right to accounting disclosures. You may request a list of the disclosures of your mental health information that have been made to persons or entities other than for treatment or health care operations in the last 6 years, but not prior to April 14, 2003.
+ Right to a copy of this Notice. You may request a paper copy of this Notice at any time.
+ Law enforcement. (Such as in response to a court order or other legal process.)
+ To prevent a serious threat to health or safety.
+ To carry out treatment & health care operations such as through medical transcription services..
+ To military command authorities if you are a member of the armed forces or a member of a foreign military authority.
+ National security & intelligence activities.
+ Protection of the President or other authorized persons for foreign heads of state, or to conduct special investigations.

Alcohol & drug abuse information has special privacy protections. Dr. Roseman will not disclose any information identifying an individual as being a client or provide any mental health information relating to a client's substance abuse treatment unless: (1) the client consents in writing; (2) a court order requires disclosure of the information; (3) medical personnel need the information to meet a medical emergency; (4) qualified personnel use the information for the purpose of conducting research; management audits, or program evaluation; or (5) it is necessary to report a crime-or-a threat to commit a crime or to report abuse or neglect as required by law.

4. YOUR AUTHORIZATION IS REQUIRED FOR OTHER DISCLOSURES:
Except as described previously, we will not use or disclose information from your record unless you authorize it in writing for me to do so. You may revoke your permission, which will be effective only after the date of your written revocation.

5. YOU HAVE RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION. You have the following rights regarding your health information, provided that you make a written request to invoke the right on the form I provide.

+ Right to request restrictions. You may request limitations on your mental health information that we may disclose, but we are not required to agree to your request. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.
+ Right to confidential communications. You may request communications in a certain way or at a certain location, but you must specil5' how or where you wish to be contacted, (Such as calling your home/office to confirm an appointment.)
+ Right to inspect & copy. You have the right to inspect & copy your mental health information regarding decisions about your care; however, psychotherapy notes may not be inspected & copied. We may charge a fee for copying, mailing, & supplies. Under limited circumstances, your request may be denied; you may request review of the denial by another licensed mental health professional chosen by me, I will comply with the outcome of the review.
+ Right to request clarified records. If you believe-the information I have about you is incorrect or incomplete you may ask to add clarifying information. You may ask for a form for that purpose. I am not required to accept the information that you propose.

6. REQUIREMENT REGARDING THIS NOTICE
Dr. Roseman is required to provide you with this Notice that govern our privacy practices. Dr. Roseman may change his policies or procedures in regard to privacy practices. If & when this occurs, the changes will be effective for mental health information I have about you as well as any information I receive in the future. Any time you come into my psychotherapy practice for an appointment, you may ask for and receive a copy of the Privacy Notice that is in effect at the time.

7. COMPLAINTS
If you believe your privacy rights have been violated, you may file a complaint with me.
You will not be penalized or retaliated against in any way for making a complaint.

Contact me if:

+ You have a complaint
+ You have any questions about this notice
+ You wish to request restrictions on uses & disclosures for health care treatment or,
+ You wish to obtain any forms mentioned to exercise your individual rights described above.

I acknowledge that I have received a copy of Dr. Roseman's Notice of Privacy Practices and consent to the use and disclosure of my Health Information for the purposes and activities permitted under the Federal Privacy Law

Patient's Signature_____ Date:_____

Just so that there are no misunderstandings about fees……..

I am a professional who has been in private practice as a psychologist for over twenty years. I look forward to be able to provide assistance to you and I appreciate the trust that you place in me. Since I began in the practice of psychology, I have always accepted insurance reimbursement, and my name may have even been provided to you by your insurance company as a participating provider in your plan. As the nature of insurance coverage has changed over the years I find that it is best to clarify the roles and responsibilities of all parties involved in this manner of payment for services rendered. Keep in mind that *Insurers routinely indicate that authorization for services does not guarantee payment, which is only determined at the time that a claim is submitted and reviewed by the insurance company claims department*

Your insurance carrier is responsible for:

1. Providing you with the specific details of your coverage for mental health services including your out of pocket expenses such as deductible amounts, co-pay amounts, and services that are not covered; prior authorization requirements and rights of appeal for denial of payment for services.

2. Payment for services covered under the terms of your contract.

Dr. Roseman is responsible for:

1. Providing your insurance carrier with all the information they require including treatment plans in a timely manner in order for them to make a determination as to what services they will pay for.

2. Abiding by the terms set forth in your insurance policy.

You are responsible for:

1. Understanding the provisions as well as limitations of your particular policy. Keeping the policy in effect throughout the course of treatment and/or informing this office of any changes in coverage.

2. Obtaining initial authorization for services when required by your policy.

3. Timely notification of a cancellation of a scheduled appointment to avoid assessment of a fee. *

4. Payment of all deductible amounts and co-pay amounts at the time that services are rendered.

5. Payment for any services rendered that are not covered by your policy or denied for payment upon review by your insurance carrier **

* No insurance company will pay for a missed or cancelled appointment; however it is my policy to assess a fee of **$100** for any session missed with less than 24 hours notice. I respect the time you set aside to meet with me and I ask that you respect my time as well. The assessment of this fee is discretionary on my part, based on the circumstances of a missed appointment; however I reserve the right to not set further appointments until the matter of a missed appointment is resolved.

** Insurance companies do not pay for reports, letter writing, telephone consultations, school consultations or legal proceedings. While certain correspondence will be provided as a courtesy (i.e. a brief letter to excuse someone from work or school), other, more involved correspondence prepared at your request, the request of an attorney or outside agency or ordered by a court will result in a fee for time involved, in much the same way that an attorney or accountant would charge you for services rendered. If the psychological services requested are for matters involving legal proceedings, i.e. custody, visitation, probation, expert testimony, etc., a retainer may be required.

In most instances insurance covers only therapy sessions and in some instances only individual, but not marital or family therapy. Rarely do insurance companies pay for psychological testing, particularly IQ testing and other psycho-educational testing. In certain instances an insurance company may pay for testing, but the rate of reimbursement is so low that I will not accept those fees as payment in full and it must be supplemented with out of pocket expenses. I reserve the right to decline to accept the rate for reimbursement your insurance company will pay for psychological testing. No report will be released until payment in full has been received for psychological testing.

In order to minimize disruption of services and to avoid conflicts in advance, this office requires that you provide valid credit or debit card information. This manner of payment may be used to cover fees associated with a missed appointment without adequate notification or valid fees for services rendered but denied for payment by your insurance carrier. ***No charges will ever be made unless you have been specifically informed of the charge and reason for it****. If you are unable or unwilling to provide this information, or provide an alternative means of assuring payment, Dr. Roseman reserves the right not to initiate services. It has been his experience that adherence to this policy dramatically reduces problems in the future.*

I have read the information in this document and I agree to be responsible for all fees associated with my care and treatment provided by Dr. Roseman that are not paid for by an insurance company or any other third party. In order to minimize bookkeeping or disruption of services I authorize Dr. Roseman to post appropriate charges to my credit or debit card. I understand that I will be informed in advance of any charges and I recognize that I will be responsible for payment by other means if the credit card charge is not approved.

Signature of Responsible Party:_____ Date_____

(circle one) Credit Card Debit Card (circle one) Visa Master Card Amex Discover

Name on Card_____

Card Number ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Expires _____