

**Associates for Human Development, P.A.  
2699 Stirling Road, Suite A-105  
Hollywood, FL 33312**

**Directions to the Office**

The office is located on the northeast corner of Stirling Road and Park Road in the Emerald Park Office Center.

From **I-95**, take the Stirling Road exit heading west. At Park Road take a right and the first immediate right, which is the entrance to the complex. Parking is available both in the front and to the West and East sides of the buildings.

The office is located in Building A, ground floor, Suite 105 just outside the elevators.

When you come in, tap lightly on the window, take a seat and you'll be greeted shortly.

**IMPORTANT:**

- **Please read through, complete and sign the enclosed forms and bring them with you to your initial appointment. Please arrive 10-15 minutes before your appointment time.**
- ***We ask that you give 24 hours notice if you are unable to keep your appointment, or a minimum of \$75 will be charged to your credit card for the time reserved. Voicemail is available 24/7 and does suffice for giving adequate notice.***
- **If you are using insurance benefits, please bring your health insurance card. Failure to do so will result in you being held responsible for the full cost of this session.**
- **Be certain to contact your Mental Health carrier in advance to obtain authorization if necessary. In most instances a referral from your primary physician is unnecessary but an authorization from the carrier or its mental health agent may be required. If you are uncertain check with them; the phone number is usually on the insurance card under *Mental Health/Substance Abuse*.**
- **If authorization is required and not obtained, you will be responsible for the full fee for the visit. Retroactive authorization will not be requested.**
- ***Please turn off cell phones* when you arrive and do not bring food or pets into the office.**
- **Unless the client is a child, please make alternative child care arrangements. Do not bring other family members or friends to the appointment unless specifically asked to do so. The waiting room has limited space and your guests may not be allowed into the session.**

*We look forward to seeing you and being of assistance.*

**Associates for Human Development, P.A.**  
**New Client Information**

**Patient Name** \_\_\_\_\_ **Age** \_\_\_\_\_ **Gender** \_\_\_\_\_

**Address** \_\_\_\_\_

**City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_ **Email** \_\_\_\_\_

**Date of Birth** \_\_\_\_\_ **Social Security Number** \_\_\_\_\_

**Primary Phone** \_\_\_\_\_ *Home /Work /Cell* **Secondary Phone** \_\_\_\_\_ *Home/ Work / Cell*

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**Primary Insurance Carrier** \_\_\_\_\_ **Policy ID #** \_\_\_\_\_

**Name of Policy Holder (if not patient)** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

**Secondary Insurance Carrier** \_\_\_\_\_ **Policy ID#** \_\_\_\_\_

**Name of 2<sup>nd</sup> Policy Holder (if not patient)** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

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**Place of Employment/School** \_\_\_\_\_

**Occupation** \_\_\_\_\_ **Marital status** \_\_\_\_\_

**Spouse's Name** \_\_\_\_\_ **Spouse's occupation** \_\_\_\_\_

**If Patient is a minor: Mother's name** \_\_\_\_\_ **Father's name** \_\_\_\_\_

**Names and ages of siblings** \_\_\_\_\_

**Parents' marital status:** married \_\_\_ living together \_\_\_ separated \_\_\_ divorced \_\_\_

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**Primary Care Physician** \_\_\_\_\_ **Tel #** \_\_\_\_\_ **Last visit** \_\_\_\_\_

**Would you describe your current physical health as** \_\_\_\_\_ **Very Good / Good / Average / Poor**

**Do you have current legal difficulties? If so, please describe** \_\_\_\_\_

**Current complaint or symptoms** \_\_\_\_\_

**What are your expectations from this consultation?** \_\_\_\_\_

**Who Referred You?** \_\_\_\_\_

**Signature of Client (or Guardian if client is a minor)** \_\_\_\_\_

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**Office Use Only:** First Appt..... Last Seen.....Date Closed.....Date Destroyed.....

**Associates for Human Development, P.A.**  
**Authorization for Release of Information**

Patient Name: \_\_\_\_\_

Date of Birth \_\_\_\_\_ SSN \_\_\_\_\_

I understand that under Florida law, communications between a patient and his/her therapist/psychologist are privileged and may not be disclosed by the treating provider unless the patient or parent/legal guardian gives written permission. I also understand that Client Records maintained by a psychologist may not be disclosed to third parties except by my expressed written consent or through the legal process. I also understand that, in accordance with HIPAA guidelines for mental health records, I **may not** have copies of the record for my files but may review the record with my counselor during a session specifically scheduled for this purpose.

To: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_ My primary care physician, Dr. \_\_\_\_\_

Phone # \_\_\_\_\_ Fax # \_\_\_\_\_

\_\_\_ My Psychiatrist, Dr. \_\_\_\_\_

Phone # \_\_\_\_\_ Fax # \_\_\_\_\_

\_\_\_ My previous therapist, \_\_\_\_\_

Phone # \_\_\_\_\_ Fax # \_\_\_\_\_

My insurance/managed care organization

\_\_\_ School Officials

Phone # \_\_\_\_\_ Fax # \_\_\_\_\_

\_\_\_ Other \_\_\_\_\_

Phone # \_\_\_\_\_ Fax # \_\_\_\_\_

I hereby authorize \_\_\_\_\_ to disclose, release, and/or obtain records on my behalf, or on behalf of my child \_\_\_\_\_. This authorization is limited to the purpose of releasing or obtaining information relevant to my case or for purposes of evaluation and treatment. This authorization shall remain in force unless revoked by me in writing.

\_\_\_\_\_  
Patient or Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

**Associates for Human Development, P.A.**  
**Client Consent**

I hereby apply for and consent to psychological evaluation and/or treatment by Associates for Human Development, PA, specifically.....for my child or myself. I understand that it is my responsibility to cooperate with evaluation and/or /treatment to the best of my ability. I understand Florida State, Federal law and professional ethical standards provide for the confidentiality of psychotherapist/ client communications including records. Your therapist and this office will not disclose or confirm your use of services at this office. Lawful and legally required exceptions to this privilege of confidentiality include; information of child abuse, elder abuse, the immediate physical danger to yourself or another, a lawful court order and your signed consent.

I hereby authorize the payment of health benefits to which I am entitled, to Associates for Human Development and/or ..... Insurance billing is performed as a convenience to me and I understand that I am responsible for all charges not covered by my carrier. I understand that I am responsible for obtaining authorization directly from my insurance carrier, PPO, HMO, or their legal representative, when requested, or conducting communications with same to facilitate payment for services. I understand that charges and/or co-payments for all services are due and payable at the time services are rendered, or as provided by state/federal statute or regulation.

Because time has been reserved for me and/or members of my family, except in the event of a true emergency (final decision to be made by your therapist), I am expected to provide at least 24 hours advanced notice if I am unable to keep a scheduled appointment. In the event that the office is closed, date and time stamped voicemail is available 24 / 7 and does suffice for giving adequate notice. **If I miss my appointment or fail to provide such notice, I will be billed and/or my credit card will be charged a minimum of \$75 for the time reserved, or the full session fee. Returned checks will not be represented to your bank and a fee of \$25 will be assessed.**

*(Insurance carriers **will not** pay for missed appointments.)*

I understand that insurance benefits, if any, will pay only for therapeutic sessions. Time spent on telephone calls, preparation of letters or reports, psychological testing, or attendance at schools, depositions, legal proceedings, or other conferences, whether for me or my child, is my financial responsibility and will be billed at the prevailing hourly rate (\$100 per hour) for those services. In addition, should this account be sent to an outside Agency for collection of a balance due, the client will be responsible for all and any fees assessed.

My full signature below indicates that I have read and agree to all policies.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## **HIPAA Notice of Privacy Practices**

**Associates for Human Development, P.A.  
2699 Stirling Road, Suite A-105  
Hollywood, FL 33312  
954.989.8818**

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

**Uses and Disclosures of Protected Health Information:** Your PHI may be used and disclosed by your provider, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the provider's practice, and any other use required by law.

**Treatment:** We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your PHI, as necessary, to a home health agency that provides care to you. For example, your PHI may be provided to a physician to whom you have been referred to ensure that the provider has the necessary information to diagnose or treat you.

**Payment:** Your PHI will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant PHI be disclosed to the health plan to obtain approval for the hospital admission.

**Healthcare Operations:** We may use or disclose, as-needed, your PHI in order to support the business activities of your provider's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your PHI to medical school or graduate students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your provider. We may also call you by name in the waiting room when your provider is ready to see you. We may use or disclose PHI, as necessary to contact you to remind you of your appointment.

We may use or disclose your PHI in the following situations without your authorization. These situations include: as required by law, public health issues as required by law; communicable diseases; health oversight, abuse or neglect; Food and Drug Administration requirements; legal proceedings; law enforcement; coroners, funeral directors, and organ donation; research; criminal activity, military activity and National Security; Workers' Compensation; inmates required uses and disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

**Other Permitted and Required Uses and Disclosures** will be made only with your consent, authorization or opportunity to object unless required by law.

**You may revoke this authorization,** at any time, in writing, except to the extent that your provider or the provider's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

## Your Rights

Following is a statement of your rights with respect to your protected health information. (PHI)

**You have the right to inspect and copy your protected health information.** Under federal law, however, you may not inspect or copy the following records: *psychotherapy notes*; information compiled in reasonable anticipation of or use in a civil, criminal, or administrative action or proceeding; and PHI that is subject to law that prohibits access to PHI.

**You have the right to request a restriction of your protected health information.** This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your written request must state the specific restriction requested and to whom you want the restriction to apply.

Your provider is not required to agree to a restriction that you may request. If the provider believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You then have the right to use another Healthcare Professional.

**You have the right to request and receive confidential communications from us by alternative means or at an alternate location. You have the right to obtain a paper copy of this notice from us upon request, even if you have agreed to accept this notice alternatively i.e., electronically.**

**You may have the right to have your provider amend your protected health information.** If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

**You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.** We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

## Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint.

**We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Your signature below acknowledges that you have read and understand this Notice of our Privacy Practices, a copy will be made available to you upon request.

Printed Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_