Douglas Wythe, LCSW

330 West 58th Street, Suite PH F

New York, NY 10019

917-617-1994

dougwythe@gmail.com

Patient Name:

Date of Birth:

Mailing Address:

Email Address:

Mobile Number:

Marital Status:

Social Security Number:

Emergency Contact:

Consent to Communicate via E-Mail

I hereby consent to have Douglas Wythe, LCSW, communicate to me via email. I understand that e-mail is not a confidential method of communication and that emails could be intercepted by third parties or transmitted to unintended parties. I understand that any email I send will become part of my medical record. I understand that in an urgent or emergent situation, I should call my provider or go to the nearest Emergency Room and not rely on e-mail.

Signature:

Date:

Consent to Treatment and Cancellation Policy

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, acknowledge that I have had all my questions about treatment answered fully and to my satisfaction.

I seek and consent to take part in treatment with Douglas Wythe, LCSW. I understand and agree to play an active role in the therapy processes.

I understand that no promises have been made to me about the results of treatment or of any procedures provided by this therapist.

I am aware that I may stop my treatment with this therapist at any time. If I do, I will have to pay for the services I have already received. I understand that I may lose other benefits or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.)

I am aware that my health insurance company or other third-party payer may be given information about my diagnose(s) and life functioning, as well as the type(s), cost(s), date(s), and providers of any services or treatments I receive. I understand that if payment for the services I receive here is not made, the therapist may stop my treatment.

CANCELLATION POLICY: **I know that I must contact Mr. Wythe to cancel an appointment AT LEAST 24 HOURS before the time of the appointment. If I do not cancel or do not appear (either in person or virtually), I will be charged for that appointment.**

My signature below shows that I understand and agree with all of these statements.

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 Signature of client or legal representative          Printed name            Date

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   Printed name of legal representative

Notice of Privacy Practices (Brief Version)

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.

My commitment to your privacy

As part of providing professional care to you, we will do all we can to maintain the privacy of what is called your “protected health information” (PHI). We are also required by law to keep your PHI private. These laws are complicated, and we must give you this important information. This page is a shorter description of what we do to maintain your privacy. If you would like to read the more detailed version, please ask any staff member for a copy. If you have any questions about our practices, please contact our compliance officer, whose information is listed at the bottom of this page.

How we use and disclose your protected health information (PHI) with your consent

We will use the information we collect about you mainly to provide you with treatment; to arrange payment for our services; and for some other business activities called, in the law, “health care operations.” We will ask you to sign a separate consent form to show that you understand these ways we handle your information. If you do not agree and won’t sign this consent form, we will not treat you. If we want to use or send, share, or release your PHI for other purposes, we will discuss this with you so you fully understand it, and ask you to sign a release-of-information form to allow this.

Disclosing your health information without your consent

There are some times when the laws require us to share your information without getting your consent. They are described in the longer version of our Notice of Privacy Practices, but here are the most common situations:

1. When there is a serious threat to your or another person’s health or safety or to the public. We will only share information with people who are able to help prevent or reduce the danger.

2. When we are required to do so by lawsuits and other legal or court proceedings.

3. When a law enforcement official requires us to do so.

4. For workers’ compensation and some similar programs if you seek these benefits.

Your rights about your health information

1. You can ask us to communicate with you in a particular way or at a certain place that is more private for you. For example, you can ask us to call you at home, rather than at work, to schedule or cancel an appointment. We will try our best to do as you ask.

2. You can ask us to limit what we tell people involved in your care or the payment for your care, such as family members and friends.

3. You have the right to look at the health information we have about you, such as your medical chart, case file, and billing records. You can get a copy of these records, and we can charge you for it.

4. If you believe that the information in our records is incorrect or missing something important, you can ask us to make additions to your records to correct the situation. You have to make this request in writing.

5. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with the Secretary of the U.S. Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care we provide to you in any way.

6. You have the right to a copy of this notice.

Also, you may have other rights that are granted to you by the laws of our state, and these may be the same as or different from the rights described above.

My signature below indicates that I have received this Notice of Privacy Practices.

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

Date:

Agreement to Pay for Professional Services

I request that Douglas Wythe, LCSW, provide professional services to me.

 I agree to pay the fee of $ 250.00 per (50) minute individual session/ $325.00 per (60) minute couples session.

I understand and agree that I am responsible to pay the charges for services provided by this clinician.

I agree to pay for services provided to me up until the time we end the relationship.

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            Signature of client (or person acting for client)                Date

           Printed name of client (or person acting for client)

I, the clinician, have discussed the issues above with the client (and/or the person legally acting for the client). My observations of the person’s behavior and responses give me no reason to believe that this person is not fully competent and able to give informed and willing consent.

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                 Signature of clinician                     Date