Joel Ziff, Ed.D., Psychologist
22 Mt Auburn Street, Watertown, Massachusetts 02472
Phone: 617-965-3932 • joel@ziffgroup.com • www.ziffgroup.com

Client Information Form

Name_____. **Birthdate**_____

Cell Phone_____ **Email**_____

Address_____

City_____ **State**_____. **ZipCode**_____

Additional household members

Name_____ **Relationship** _____. **Birthdate**_____

Cell Phone_____ Email_____

Name_____ **Relationship** _____. **Birthdate**_____

Cell Phone_____ Email_____

Name_____ **Relationship** _____. **Birthdate**_____

Cell Phone_____ Email_____

Payment Information

I will be making payment via:

___ Zelle (user ID: 617-821-4425)
___ Venmo (User ID: joel-ziff – verification code: 4425)
___ Credit Card - I will give you credit card information when we meet
___ Credit Card – Here is my information to keep on file:

Credit Card Number (MC or VISA only) _____

Expiration Date: _____. Security Code _____. Billing Zip Code _____

Billing Address:_____

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Preferences Regarding Length of Sessions

Limit session length to __25-30 minutes __35-40 minutes ___45-50 minutes __55-60 minutes.
___ Session length can vary depending upon what is needed

Preferences Regarding Billing

___ Please send bills only when I have a balance due.
___ Please always send bills to show charges and payments, including when I have a zero balance.

Preferences Regarding Communication Via Email/Text

I understand that communication via email to/from joel@ziffgroup.com is secure and private, meeting HIPAA regulations for protection of Personal Health Information (PHI). Communication via text is not secure and I understand that my privacy may not be protected. Please indicate your preferences regarding email communication:

I agree to receive communication from you via
____ email regarding scheduling/appointments
____ email regarding billing.
____ email regarding other topics, including issues discussed in therapy.
____ text messages regarding scheduling and appointments
____ I do not want to receive communication from you via email or text on any topic.
Use this email address for communication: _____

Use this phone number for communication via text: _____

ACKNOWLEDGEMENT OF RECEIPT

Notice of Policies and Practices to Protect the Privacy of Your Health Information

The Health Insurance Portability and Accountability Act (HIPAA) is a federal law that provides privacy protections and patient rights regarding the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment and health care operations. HIPAA requires that I provide you with the *Notice.* The *Notice* explains HIPAA and its application to your PHI in greater detail. The law requires that I obtain your signature to acknowledge that I have provided you with this information by the end of this session.

Your signature(s) below serves as an acknowledgement that you have received the HIPPA notice of privacy practices and the 'Information for Clients' (05/21) statement that describes cancellation, insurance, and billing policies as well as policies regarding reimbursement by insurance for phone and video sessions.

_____ _____

Signature(s) **Date**

_____

Please Print Your Full Name(s)