

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 Insurance

I will be submitting claims directly for reimbursement from my insurer or Health Care Reimbursement Account (HCRA). (For all insurers except BC/BS)
 Please submit claims for me to BC/BS. (Fill out separate form included below)
 I will NOT be submitting claims for insurance.

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.
(Select this option if you will be submitting bills to your insurer for reimbursement.)

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:

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
 text messages regarding other topics, including issues discussed in therapy.
 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 HIPAA notice of privacy practices and the 'Information for Clients' (11/22) 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)