Taube Levitt MFT - License # 34972
15615 Alton Parkway, Suite 450, Irvine, CA 92618
Phone: (714) 716-9905
www.taubelevitttherapy.com

Referred by: _____

Last Name: _____ First Name: _____ Middle Initial:

Address: _____ City: _____State: _____ Zip: _____

DOB: _____ Age: _____ SS#: _____ Driver's License #: _____

Marital Status: _____ Gender: ___ Ethnicity: _____ Occupation: _____ Education Year:

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Emergency Contact Name: _____ Home Phone: _____ Cell Phone: _____

Email: _____Emergency Contact and telephone #:_____

HOW WOULD YOU LIKE ME TO CONTACT YOU? □ Phone □ Text □ Email

Insurance Information

Primary Insurance Company: _____ Phone #: _____

Identification #: _____ Group #: _____

Name of Insured: _____ Relationship: _____ DOB: _____

Secondary Insurance Company: _____ Phone #: _____

Identification #: _____ Group #: _____

Name of Insured: _____ Relationship: _____ DOB: _____

All charges are the direct responsibility of the patient. Payment is due at the time services rendered. I hereby authorize the release of my behavioral health information, if necessary, to process a claim or for further treatment.

For Contracted Insurance Patients: I hereby assign my insurance benefits to be made directly to Taube Levitt, MFT for services rendered. I hereby attest that the above insurance information is accurate and that I am an eligible member. I understand that I am responsible for knowing my benefits/coverage. I will be financially responsible for all the charges that are not covered by my insurance company.

Name: _____ Signature: _____ Date: _____

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FINANCIAL AGREEMENT AND ASSIGNMENT OF BENEFITS

The undersigned, whether he/she/they sign as an agent or as patient, hereby agrees to pay the account in accordance with regular rates and terms of service rendered to the patient by Clinician.

Please note that I verify eligibility/benefits of your insurance prior to the first appointment. However if any changes occurs (co-pay or deductible, etc.) the difference will be rendered at the time of the visit. (Please initial)

A request for copies of medical records is **$75.00**.

For any patient litigation, as it takes time to prepare and do reports, the pay rate is $150 an hour to be paid up front.

Should the account be referred to an attorney and/or for collections, the undersigned hereby agrees to pay reasonable attorney fees and /or collection expenses. The undersigned accepts terms hereof, certifies that she/ he/they have read the forgoing, and is the patient or is authorized to sign as the patients agent.
(Please initial)

If fees are not paid, termination may be a consequence.

PLEASE BE AWARE THAT IT IS YOUR RESPONSILIBITY TO KNOW THE DETAILS OF YOUR HEALTH PLAN.

Please call your insurance carrier regarding policy, benefits, deductible amounts, co-pay, co-insurance and other related topics before your appointment.

Thank you for understanding and contacting your insurance carrier for checking your benefits before your scheduled appointments.

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HIPAA Privacy Notice

In accordance with the Health Insurance Portability and Accountability Act of 1996, patients of this practice are entitled to the greatest degree of privacy. This office will strive to ensure that patient information is used only for authorized purposes as agreed to by the patient. Patients are advised that they have a right to review their medical /Psychological files upon reasonable notice to the practice and during normal business hours, and to make comments to the same. Patients have the right to direct the methods of communication of their medical information and to specify the individuals to whom they wish their medical information released to, in addition to those indicated on the "Consent to Release Psychological Information" form.

Practice Policies and Procedures

- Before any records are released, staff will review to ensure that only the information necessary has been released.
- Before any records are released, staff will review to ensure that the release has been authorized by the patient or is otherwise permitted by law.
- Except in emergencies or as required by law, the patient (or the patient's agent) shall be notified before any records are released.
- Sign-in sheets used in the waiting room will not contain any medical information/ reason for patient's visit.
- Only licensed healthcare professional members of the staff shall have access to medical/ Psychological records. Other staff members shall have access limited to portions of the records directly related to their duties (for example, the secretary shall have access to the pharmacy records for the purpose of refilling prescriptions).
- At the close of business each day, all medical information shall be secured in a protected area marked "confidential" or in locked cabinet or in the chart room.
- Each patient's chart shall include records of all releases of information, including the date, to which the information was sent, and the material included.
- Oral PHI (Protected Health Information) should not be communicated in general patient areas. Except in emergencies, all discussions regarding patient care shall be conducted either in private settings or in the clinicians' office.
- Oral PHI should not involve unnecessary parities. Discussions concerning patients should never be made in another patient's examination room.
- Common area conversations concerning patients are to be avoided.
- Out-of-office conversations regarding PHI are forbidden.
- Parents and minors
- Only the parent or legal guardian of a child has the right to access records.
- Exceptions include:
- State law pre-emption (e.g., applicable state law concerning pregnancy or sexually transmitted diseases)
- Court order
- Potential abuse or neglect
- With parent or guardian consent

Receipt of Privacy Notice

By signing below, I confirm that I have received and read the privacy notice given to me in accordance to HIPPA.

Signature:_____ **Date**:_____

If person other than patient is signing, please print full name and indicate relationship below.

Print Full Name: _____ **Relationship to Patient**:_____

Any questions regarding this privacy notice should be directed to this practice's HIPPA compliance

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Cancellation/ No show Policy:

Cancellations and rescheduling of new patient and follow-up appointments require at least 2 business days (48 hours) notice IN ADVANCE to avoid a fee. You will receive a confirmation text the day before your appointment and will be asked to confirm by a certain time. If no confirmation is received, it will be assumed you are unable to keep that appointment and your slot will be given to another client.

If you do not give me advance notice to cancel or reschedule your appointment (new or follow up), a $100.00 cancellation fee will be charged. If you miss two or more appointments, I reserve the right to no longer see you and refer you out to other therapists.

I understand that situations arise and patients may need to change appointments. I'm happy to work with you to reschedule appointments. I sincerely appreciate your consideration and cooperation.

By signing below, I acknowledge that I have read and accept the above cancellation policy,

_____ _____
Signature Date

_____ _____
Printed Name Relationship to patient

Your credit card information will be collected and will be charged at the time of service for the following reasons:

a. Late appointment cancellation / No show
b. Your health plan applicable deductible at the time of service
c. Your health plan copay/coinsurance applicable at the time of service
d. Any medical record request

By signing below, I acknowledge that I have read and accept the above policies:
(Please initial _____) Date: _____

Policy Method: ☐ American Express ☐ Visa ☐ MasterCard ☐ Discover

Credit Card Number:_____ Exp. Date:_____

Name on the card_____ Billing Zip code:_____ CVV:_____