Dr. Selma Nemer, Clinical Psychologist
One Roof, 58 Henry Street • Saratoga Springs, NY 12866
P: 518.581.3180, ext. 307

PATIENT INFORMATION

Name: _____ DOB: _____

Address: _____
Street Apt. City State Zip

E-mail: _____

Phone numbers:
Home: _____
Cell: _____
Other: _____

PAYMENT AUTHORIZATION

☐ Self-Pay – $150.00 for the first intake session and $140.00 for each subsequent session.

I authorize Dr. Nemer to generate a CMS-1500 for submission to my insurance company (which I understand I must submit in a timely manner for possible—not guaranteed--reimbursement). I agree that Dr. Nemer can release, to my insurance company/companies, information from my records that may be necessary for the insurance company/companies to process claims for services provided. I agree to notify Dr. Nemer immediately of any changes to my insurance, and understand that if any denials occur for her services as an out-of-network provider, that I am still fully responsible for the session fees due. I understand that it is my responsibility to consult with my insurance company for possible reimbursement, as I am entering into a self-pay arrangement with Dr. Nemer for her counseling services.

_____ _____
Signature of Patient Date

_____
Print Name

OFFICE POLICIES AND PROCEDURES

- **Sessions are 45-50 minutes in length**. Some end-of-session time may be devoted to phone calls and/or paperwork on your behalf. The initial intake appointment is a full hour, with additional time spent in communication with other providers as needed (not exceeding 10-15 mins.)
- Please arrive on time for your appointment. Lateness will result in reduced session time.
- If you need to reschedule, please do so with **24-hour notice**, by calling (518) 581-3180, ext. 307 and leaving me a voicemail. Barring emergencies requiring documentation, cancellations with less than 24 hour notice will incur a $50.00 dollar fee.

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INFORMED CONSENT FOR TREATMENT

I, (Client) _____, will be receiving psychotherapy from Dr. Selma Nemer. These services will be confidential in nature with a few exceptions:

- If there is an allegation of child or elder abuse or neglect it will be necessary for me to share pertinent information with the proper authorities.
- If there is an expressed intention to harm yourself or someone else, pertinent information would be shared with proper authorities to prevent such harm.
- Whenever permission has been granted in writing by you, information may be shared with the identified entity.
- Information may be released to third party payers, such as your insurance company's carve-out payment vendor, for the purposes of receiving payment for services. This information will be limited to the information relevant to receive payment.

_____ _____
Signature of Patient Date

_____ _____
Print Name

I agree that I have read and understand the above information pertaining to the therapy contract, and office policies/procedures and agree to its terms and give informed consent for treatment. I understand that if I have additional questions or concerns regarding these matters, I will ask that they be addressed.

_____ _____
Signature of Patient Date

NOTICE OF PRIVACY PRACTICES
RECEIPT AND ACKNOWLEDGMENT OF NOTICE

Patient Name: _____

DOB: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Dr. Nemer's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Dr. Nemer.

_____ _____
Signature of Psychologist Date

PRIVACY OFFICER INFORMATION

I am the HIPAA Privacy Officer for my private practice (518-581-3180, ext. 307). I can:

- ❖ Can answer your questions about privacy practices.
- ❖ Can accept any complaints you have about our privacy practices.
- ❖ Can give you information on how to file a complaint.