Andrew Merling Ph.D. LLC

330 West 58th Street, Suite 18F

New York, NY 10019

917-882-4471

amerling50@gmail.com

www.drmerling.com

Patient Name:

Date of Birth:

Mailing Address:

Email Address:

Mobile Number:

Marital Status:

Emergency Contact:

If you have United UMR Top Tier Insurance Through Mt. Sinai Please Complete the Following:

Policy Number:

Group Number:

Are you the primary insured?

If not, please provide the following:

Name of Primary Insured:

Primary Insured’s Date of Birth:

PLEASE EMAIL OR TEXT ME A COPY OF THE FRONT OF YOUR INSURANCE CARD (only if you have United UMR Top Tier)

Consent to Communicate via E-Mail

I hereby consent to have Andrew Merling Ph.D. 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 Dr. Andrew Merling. . 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 Dr. Merling to cancel an appointment AT LEAST 48 HOURS before the time of the appointment. If I do not cancel within that time frame or do not show up, I will be charged for that appointment. Cancellat*ion* charges for people with insurance will be determined by whatever the contracted rate is for the service that was going to be provided.**

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

  Printed name of legal representative          Relationship to client

What You Should Know about Managed Care and Your Treatment

Your health insurance may pay part of the costs of your treatment, but the benefits cannot be paid until a managed care organization (MCO) authorizes payment. The MCO has been selected by the insurer your employer chose, not by you or me. The MCO sets some limits on us, and you need to know what these are before we go further.

Confidentiality

If you expect to use your health insurance to help pay for psychotherapy, you must allow me to tell the MCO about your problem or problems and give you a psychiatric diagnosis. You must also permit me to tell the MCO about the treatment I am providing, about your progress during treatment, and about how you are doing in many areas of your life (your functioning at work, in your family, your social life, and in activities of daily living). I am not paid separately for collecting, organizing, or submitting this information, and I cannot bill you for these services. All of this information will become part of the MCO’s records, and some of it may be included in your permanent medical record at the Medical Information Bureau, a national data bank. It is not open to the public, but it may be examined when you apply for life, disability, or health insurance.

All insurance companies and MCOs claim to keep the information they receive confidential, and there are federal laws about its use and release. Those laws apply to me as well as other laws and codes of ethics that are much stricter. If you are concerned about who might see your records now or in the future, we should discuss this concern more fully before we start treatment. You should evaluate your situation carefully in regard to confidentiality. For some people and some problems, extreme privacy of their communications to their therapist is absolutely essential to their working on their difficulties. For others, their problems are not ones that raise much concern over confidentiality and they are comfortable with the usual protections.

Treatment and Payment

If I have a contract with your MCO, I am one of its providers, and so I am “in network” and must charge you the fee that the MCO and I have agreed to. You will pay me the full fee until your payments reach the yearly “deductible” of your health insurance. After that, you will pay me only the copay at each session.

I am not on all insurance panels, and it is possible that your insurance plan has coverage or benefits payable to providers who are “out of network.” If so, it may be possible for me to negotiate a special fee arrangement between me and your MCO.

The MCO will review the information I send it and then effectively decide how much treatment I can provide to you. The MCO can refuse to pay for any of your treatment, or for any treatment by me. Or it may pay only a very small part of your treatment’s cost (because of deductibles, coinsurance, and copayments), and later it can prevent me from charging you directly for further treatment we agree to pursue.

* The MCO may verify your eligibility for payment and then later decide that this was in error and require you (or me, if it paid me) to return the payments received (these are “retroactive denials”).

It can set limits on the kinds of treatments I can provide to you by refusing to pay for them. It will decide which are not “medically necessary.” The ones it authorizes may not be the best suited to your difficulties or in your long-term best interest, and it may not agree to pay for those that we might consider most beneficial.

Not all services may be covered, including phone meetings, video conferencing, and sessions that are deemed medically unnecessary. If you request or agree to services that are not covered, you will be expected to pay for them, and we will sign an additional contract.

The MCO will approve treatment aimed at improving the specific symptoms (behaviors, feelings) that brought you into therapy. It will usually not approve any further treatment, even if you and I believe it is needed to fully relieve your problems, or if we believe that undertreating your problems may prolong your distress or lead to relapses (worsening), or if we feel that more sessions will help you function much better than before.

The MCO may stop its payments because it believes that you have made sufficient progress and no longer need treatment. If the MCO denies payment before either of us is satisfied about progress, we may also need to consider other treatment choices, and those may not be the ones we would prefer.

I will discuss with you any efforts the MCO makes to get me to limit your care in any way.

You should know that my contract or your employer’s contract with a particular MCO prevents us from taking legal actions against the MCO if things go badly because of its decisions.

Our Agreement

If, after reading this handout and discussing it with me, you are concerned with these issues, you may have the choice of paying me directly and not using your health insurance. This will create no record outside of my files. This possibility requires that I don’t have a contract with your insurer or MCO.

My signature below indicates that I have read and understood the issues described above, and willingly enter treatment accepting these conditions and limitations. I give my therapist permission to submit information in order to secure payment for the mental health services to be provided to me.

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     Signature of client           Printed name of client      Date

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. I understand a more detailed version of this is posted on Dr. Merling’s website for my review. [www.drmerling.com](http://www.drmerling.com) .

Signature:

Date:

Agreement to Pay for Professional Services

I request that Andrew Merling Ph.D. provide professional services to me.

 I agree to pay the agreed upon fee per 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