FINANCIAL RESPONSIBILITY AGREEMENT

Please Complete and Bring to Your First Appointment.
Please Bring Your Insurance Cards with You.
You are Responsible for Notifying our Office of any Change in Your Insurance.

VALLEY NEUROPSYCHOLOGY GROUP
VALLEY PSYCHOLOGICAL ASSOCIATES
1045 S. Cedar Crest Blvd., Allentown, PA 18103-5443
610-433-3360

Patient's Name: _____ DOB:_____

Street Address: _____

City, State & Zip Code: _____ Social Security No:_____

Home Telephone Number: _____ Work: _____ Cell: _____

Marital Status (S,M,D,W,Sep): ____Spouse's Name: _____ Spouse's SSN: _____

Person Responsible for Payment: _____

Primary Insurance Company Name: _____Phone Number: _____

Insurance Company Address: _____

Insured's Name and Address: _____

Insured's Date of Birth: _____ Insured's Telephone No: _____

Insured's I.D. No: _____ Insured's Group No: _____

Patient's Relationship to Insured: _____

Secondary Insurance Company Name: _____Phone Number: _____

Insurance Company Address: _____

Insured's Name and Address: _____

Insured's Date of Birth: _____ Insured's Telephone No: _____

Insured's I.D. No: _____Insured's Group No: _____

Patient's Relationship to Insured: _____

As advocates for our patients, we will make every effort to access the maximum benefits allowed under your third party payer contract ("insurance"). It is important that you understand that your benefits contract may have an "allowable amount" for each procedure, and may deny coverage entirely. You are then responsible for payment of the balance due, which may include your deductible (if not already satisfied), the co-payment, and any remaining portion of the bill that is not covered. Financial responsibility for services you receive at the office is yours alone. Thank you for your confidence in our office. We look forward to providing you with excellent care and service.

I HAVE READ THE ABOVE STATEMENT AND UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CARE AND SERVICES PROVIDED TO ME AND/OR MY DEPENDENTS.

Name of Responsible Party: _____ Relationship to Patient: _____

Signature: _____ Date: _____

OFFICE POLICIES AND PROCEDURES

We have developed this guide to our office policies and procedures to provide answers to questions about fees, appointments, insurance, messages, and other issues. Please read this guide carefully. If you have any further questions or concerns, please feel free to discuss them with either Dr. James or Dr. Meredith Margolis.

Services Offered

We will offer services specifically designed to help you. The services may include individual, marital, or family psychotherapy, psychological testing, or forensic services. If it appears that you might benefit from medication, we will help you find a local physician who will evaluate your need for medication and who will provide brief check-up appointments to monitor your response to medication.

Appointments

Barring rare emergencies, you will be seen at the time scheduled. Because this time is set aside just for you, it is important that you keep this appointment. We do understand that circumstances may arise which necessitate the cancellation of occasional appointments. In these cases, we ask that you give at least 24 hours' notice of any appointment that you need to cancel. This will allow us to offer your time to another patient. We will charge you for all appointments missed without 24 hours of advance notice.

Costs of Services

Our fee is $150 an hour for psychotherapy and psychological testing. Except for very brief reports or messages, you will be charged for phone therapy, report writing, or other professional services at this rate. Payment is required at the time of service unless other arrangements have been agreed upon. Patients who owe money and fail to make arrangements to pay may be referred to a collection agency. In the event of such a referral, your personal information will, by necessity, be given to the agency.

Health Care Insurance

Many health insurance policies cover the services of psychologists. Nevertheless, reimbursement varies considerably from company to company and from policy to policy. In addition, many policies do not cover psychological testing. Most policies also have annual deductibles, copayments, or other limits on benefits. Read your policy carefully and be aware of what is or is not covered. You may wish to call the personnel department of your employer, or the insurance carrier directly, to ask about your benefits. In most cases, we will file claims directly with your insurance carrier, and bill you for any remaining balance. Remember, it is you who is ultimately responsible for payment.

Confidentiality

Psychological services are best provided in an atmosphere of trust. You expect us to be honest with you about your problems and progress. We expect you to be honest with us about your expectations for services, your compliance with medication, and any other barriers to treatment.

Because trust is so important, all services are confidential. Everything you say to us will remain within the office walls. Nevertheless, we are required by law to make exceptions in narrow circumstances such as when there is ongoing child abuse, immediate danger to another person or yourself, or other rare circumstances.

Emergencies

Patients with emergencies should call 911. Alternatively, you may wish to call the office, or go immediately to your local emergency room. If we are not immediately available, our outgoing voicemail message will list the next appropriate steps to take.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

_____ _____

Signature Date

_____ _____

Parent or legal guardian signature if minor Date

James K. Margolis, Ph.D.
Meredith R. Margolis, Ph.D.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED, DISCLOSED AND HOW YOU MAY GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

Federal and state law requires us to maintain the privacy of your health information. The law also requires us to give you this notice about our privacy practices, our legal duties and your rights concerning your health information. We must follow the privacy practices as described in this notice while it is in effect. This notice takes effect April 14, 2003 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such applicable law permits the changes. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all health information we maintain, including health information we created or received before we made the changes. Prior to making any significant changes in our privacy practices, we will change this notice and make the new notice available upon request.

You may request a copy of your notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

USE AND DISCLOSURE OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment and health care operations. For example:

Payment: We may use and disclose your health information to obtain payment for services we provide you. We may also disclose your health information to another health care provider or entity that is subject to the federal Privacy Rules for its payment activities.

On Your Authorization: You may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any uses or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters.)

For Your Safety and the Safety of Others: If we determine that you are a danger to yourself or others, we will take all necessary steps to protect those at risk, including informing the Police and Crisis Intervention.

Please Complete and Bring to Your First Appointment

James K. Margolis, Ph.D..
Meredith R. Margolis, Ph.D.

INSTRUCTIONS & ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE

This notice of Privacy Practices includes information HIPAA Privacy Rules requires our office to give patients regarding our privacy practices. We are required to provide this notice to each patient no later than the patient's first date of service effective April 14, 2003. We must also have copies of the notice in our office available for any patient's request. Our notice must be posted in a prominent area where it is reasonable to expect any patient will be able to read. If there are any revisions to the notice, we must make it available upon request on or after the effective date of the revision in a manner consistent with the above instructions. Following, we must give our revised notice to each new patient at the time of service and to any person requesting a notice and post the revised notice as aforementioned.

Our office must make a good faith effort to obtain written acknowledgement of receipt of this notice with each patient with whom we treat and provide this notice, except in an emergency situation. If we are unable to obtain the acknowledgement, we must document our efforts and the reason we did not obtain it. The acknowledgement or lack thereof should be filed in the patient's medical record.

Patient Last Name:_____ **Patient First Name:**_____

Minor Last Name: _____ **Minor First Name:** _____

_____ _____

_____ _____

Address:_____

Telephone No: _____

Thank you very much for taking time to review how we are carefully using your health information. If you have any questions, we want to hear from you. If not, we would appreciate very much your acknowledging your receipt of our policy by signing and returning this sheet. We look forward to seeing you again soon!

I, _____**acknowledge that I have received the notice of privacy practices from James K. Margolis, Ph.D. or Meredith R. Margolis, Ph.D.**

Signature:_____ **Date:**_____

Signature of Person Authorized to Consent for Patient: _____

Relationship to Patient: _____