Howland Psychiatry/Psychotherapy
www.howland-assoc.com

PHONE 413-664-4600
FAX 413-664-4660

I have received a copy of the office Notice of Privacy Practices.

Name: ____

Signature: ____

Date: ____________

Relationship to Patient (if applicable):______________________________

I have received a copy of the office late cancellation policy.

Name: ____

Signature: ____

Date: ____________

John S. Howland, M.D. Shahrzad Yamini, M.D. Carol Vivori, N.P Morton Broch, Ph.D Ashley Benson, LICSW

Erica Forrest, MSW, LICSW Marie Wargo, Psy. D, LMHC, CADAC James Borowski, MEd, LMHC, CRC

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AUTHORIZATION TO RELEASE/EXCHANGE MEDICAL INFORMATION

NAME:____ DOB:_________________

I authorize Howland Associates, to release and exchange medical information with respect to the treatment and diagnosis of the above referenced patient, including information relating to diagnosis or treatment of mental illness or drug and alcohol abuse.

NAME:_______________________________ ADDRESS:____________________________

PHONE:______________________________ FAX:_________________________________

NAME:______________________________ ADDRESS:____________________________

PHONE:_____________________________ FAX:__________________________________

We are requesting ANY/ALL records________ we are sending records ________

This provider would like to speak to you ________

This authorization shall expire 180 days after the date appearing below, or 180 days after the patients' final treatment, whichever is later.

Signature: _______________________________ Date:_____________________

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NOTICE OF PRIVACY PRCTICES

Your Information. Your Rights. Our Responsibilities

This Notice of Privacy Practices describes your rights regarding health information we maintain about you and a brief description of how you may exercise these rights. This Notice also describes how we may use and disclose your protected health information to carry out treatment, payment, or healthcare operation and for other purposes that are permitted or required by law. We are required by law to maintain the privacy of your health information and to provide you with this Notice of Privacy Practices with respect to your health information. We are also required to comply with the terms of our current Notice of Privacy Practices.

YOUR RIGHTS

- ❖ **You can ask for an electronic or paper copy of your medical record and other health information we have about you.**
- ❖ **You can ask us to correct health information about you that you think is incorrect or incomplete You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.**
- ❖ **You can ask us not to use or share certain health information for treatment, payment or our operations.**
- ❖ **If you pay for a service or health care item out of pocket in full, you can ask us not to share that information for the purpose of payment with you health insurer.**
- ❖ **You can ask for a list of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.**
- ❖ **You have the right to revoke an authorization at any time, except in the extent that we have already relied on it in making an authorized use or disclosure. Your revocation of an authorization must be in writing.**

Health Record Benefits and Services-Unless you object, we may use and disclose medical information to tell you about health insurance benefits or services that my be of interest to you.
Emergencies-to provide information to those involved in your treatment in an emergency situation,
Research-for research that has been approved by an Institutional Revile Board or a similar privacy board.
As required by law-to complies with applicable federal, state or local laws and to a court when a judge orders us to do so in the course of judicial proceedings or law enforcement activities.
Public Health Activities-to repost to public health authorities or to prevent or lessen a threat to health or public safety only if we obtain your agreement or if we are required or authorized by law to report abuse,neglect,domestic violence or to prevent or lessen a threat to health or public safety.
Health Oversight Activities-to health oversight agencies, such as Medicare or Medicaid and other government programs regulating heath care, and civil right laws, for activities authorized by law.
For Workers Compensation-we may disclose your health information to the appropriate personnel in order to comply with the laws related to workers' compensation or other similar programs.
Lawsuits and Disputes-if you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order, subpoena or discovery request only if I have first given you notice of the order, subpoena or discovery request.
Other types of Health Information Disclosures where No Authorization is required:

- **To communicate with your Primary Care Physician**
- **To select medical examiners and funeral directors**
- **To Military command authorities for members of the armed forces**
- **To correctional institutions for inmate concerns**
- **For organ, eye, or tissue donation**

OUR RESPONSIBILITES

We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other that described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time.

TO FILE A COMPLAINT

You can file a complaint with the U.S. Department of Health and Human Services by sending a letter to: 200 Independence Avenue, S.W., Washington, D.C. 20201 or by calling 1-877-696-6775

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LATE CANCELLATION AND MISSED APPOINTMENT POLICY

The **FULL FEE** will be charged for any session missed or cancelled without a 24-hour notice, unless your insurance plan does not allow it.

At Howland Associates each clinician sees a fixed number of clients each week. Once you schedule an appointment with one of our clinicians, that time is reserved exclusively for you. In order to successfully operate our practice we need to rely on our clients keeping their appointments. If you do not show up your insurance does not pay for the missed appointment.

Therefore, any appointment that is missed or cancelled with less than the required 24 hour notice, no matter what the reason, clients will be charged. Fees are as follows:

1 hour therapy session: $100.

Medication check: $35.

The only exception to this policy is for cancellation in severe weather. If the driving conditions are such that you do not feel safe driving to our office, please call as soon as possible. If you call us and we confirm the cancellation due to inclement weather, the cancellation fee will be waived. If you do not call, regardless of weather conditions, you will still be charged.

We have tried to make this information clear and understandable. Should you have any additional questions, please discuss this with your clinician.

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THERAPIST SIGNATURE: ____