HAILE PSYCHIATRY & PSYCHOTHERAPY GROUP
Office of Dr. Michael Marchese and Dr. Jennifer Watson

Patient Registration Form			
First Name:	Last Name:	Date of Birth:	Age:
Address:		SSN:	Gender:
City, State, Zip:		Cell Phone:	
Email:		Home Phone:	
Driver's License #:		Marital Status:	
Employer/School:	Occupation:		
Employment/Student Status:			
Reason for Visit:			
Emergency Contact Information			
Emergency Contact Person:			
Relationship to Patient:	Emergency Contact Phone:		
Primary Insurance Information			
Primary Insurance:	Provider Services # (back of card):		
Member/Policy #:	Group #:		
Policy Holder Name:	Policy Holder Date of Birth:		
Relationship to Patient:	Policy Holder Phone:		
Secondary Insurance Information			
Secondary Insurance:	Provider Services # (back of card):		
Member/Policy #:	Group #:		
Policy Holder Name:	Policy Holder Date of Birth:		
Relationship to Patient:	Policy Holder Phone:		
Medical History			
Any Medical Conditions:			
Any Known Drug Allergies?			
Current Medications:			
Pharmacy Information			
Pharmacy Name:	Phone:	Fax:	
Address: (just zip code is acceptable)			

The information provided has been completed to the best of my knowledge and is accurate:

Signature:	**Date:**

Haile Psychiatry & Psychotherapy Group

Notice of Privacy Practices

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may request a revised version by accessing our website or calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office who are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of your physician's practice.

Following are examples of the types of uses and disclosures of your protected health information that your physician's office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with another provider. We will also disclose protected health information to other physicians who may be treating you. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (specialist or laboratory) who, at the request of your physician, becomes involved in your care by aiding with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used and disclosed, as needed, to obtain payment for your health care services provided by us or by another provider. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Agree or Object:

Required by Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect and receive the information.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), or in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of our practice, and (6) medical emergency (not on our practice's premises) and it is likely that a crime has occurred.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Workers' Compensation: We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally-established programs.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. Please understand that we are unable take back any disclosures already made with your authorization.

Other Permitted and Required Uses and Disclosures That Require Providing You the Opportunity to Agree or Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information then your physician may, using professional judgement, determine whether the disclosure is in your best interest.

YOUR RIGHTS

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you for so long as we maintain the protected health information. You may obtain your medical records that contain medical and billing records and any other records that your physician and the practice uses for making decisions about you. As permitted by federal or state law, we may charge you a reasonable copy fee for a copy of your records.

****PLEASE NOTE****

Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes; information compiled in a reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and laboratory results that are subject to law that prohibits access to protected health information.

You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for so long as we maintain this information. In certain cases, we may deny your request for an amendment.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us.

If you want to exercise any of the above rights, please contact your healthcare provider (Michael Marchese, M.D. or Jennifer Watson, Ph.D.) at Haile Psychiatry and Psychotherapy Group, (352) 337-0551, 5214 SW 91st Terrace, Suite A, Gainesville, FL 32608, in person, or in writing, during normal business hours. He or she will provide you with assistance on the steps to take to exercise your rights.

This notice was published and became effective on May 21, 2018.

By signing this form, I acknowledge that I have received and reviewed the Notice of Privacy Practices:

Name (Printed):	**Date:**
Signature:	

Financial Agreement

Dr. Michael Marchese – Haile Psychiatry & Psychotherapy Group

PLEASE NOTE:

There are additional charges if sessions continue beyond the scheduled time and extend beyond 5-10 minutes... The session will be billed for the time spent in session.

PLAN A- Self-Pay Patients

1.) If I file my own insurance or do not have insurance that covers psychotherapy, I will pay the full fee ($300.00 for the initial evaluation) to Dr. Marchese on the day that services are rendered.

2.) **I AGREE TO PAY THE FULL FEE FOR MISSED APPOINTMENTS AND ALL APPOINTMENTS CANCELLED WITHOUT 24 HOURS NOTICE.** Payments must be made before or at the time of the next appointment.

3.) If I do not honor this financial agreement and develop an outstanding balance, I will pay the charges within 30 days. I agree to an interest charge of 1.5% per month (18% per year) if my balance is not paid within 30 days. If payment is not made, I waive the right to confidentiality for purpose of collection of the said fee. Any reasonable attorney fees and costs incurred by Dr. Marchese for the collection of the past due account shall be my obligation as well.

PLAN B- Insurance Payment plus Patient Responsibility (Co-pay/Co-insurance)

I authorize the release of any medical records or other information necessary to process this claim. I also authorize any payment of medical benefits to the above referenced provider for services rendered. However, it must be fully understood that the contract is between me and my insurance company and I am fully responsible for any amount not paid by my insurance.

1.) **I will submit to the office my co- payment or co- insurance on the day of my session**. The office will file my insurance and any insurance payments received are to be deducted from the balance of my account.
Co- Insurance: I will pay the percentage of my responsibility as I continue (e.g. if my insurance pays 80% of my care, I will pay 20% of each office visit).

2.) The office does not guarantee that my insurance company will pay. They will attempt at the beginning of my health care to receive verification of my policy and coverage. However, if for some reason, my insurance claim is denied, or payments are requested to be refunded, I am responsible for the full amount of my bill.

3.) The office will not enter into a dispute with my insurance company regarding my claim. This is my responsibility and obligation.

4.) **I AGREE TO PAY THE FULL FEE FOR ALL MISSED APPOINTMENTS AND ALL APPOINTMENTS CANCELLED WITHOUT 24 HOURS NOTICE**. Payments must be paid before or at the time of the next appointment.

- **Charge for a Missed Appointment is the full cost of the appointment that is billed to insurance: $175.00 for 16-30 Minute appointments or $230.00 for 32-58 Minute appointments;**
- **Charge for a Late Cancellation (less than 24 hrs notice) is: $75.00.**

5.) If I do not honor this financial agreement and develop an outstanding balance, I will pay all charges within 30 days. I agree to an interest charge of 1.5% per month (18% per year) if my balance is not paid within 30 days. If payment is not made, I waive my rights to confidentiality for purpose of the said collection fee. Any reasonable attorney fees and costs incurred by Dr. Marchese for the collection of the past due account shall be my obligation as well.

I understand and agree with all of the above office policies.

Payment Plan: (Circle one) Plan A or B

Name (Printed):	**Signature:**	**Date:**