ROBERT J MORETTI PHD & ASSOCIATES

CLIENT REGISTRATION

DEMOGRAPHIC INFORMATION

Last Name	First	M.I.	Gender
Date of Birth (MM/DD/YY)	Age	Birth Place	
Employer/School	Marital/Relationship Status		
Local Address	City	State	ZIP
Permanent Address (if different)	City	State	ZIP

Ok to contact you and leave a message here?		Ok to contact you here?	
Cell Phone	❑ Yes	Email	❑ Yes
Home Phone	❑ Yes	How did you find out about us?	
Referred by		May we thank the person who referred you to us?	❑ Yes

PRELIMINARY INFORMATION

Reason for Visit	
Health problems	Medications and Supplements
Name of Primary Care Physician	Date of Last Physical

INSURANCE INFORMATION

Insurance Company, Plan Name	Insured's ID Number	Policy Group Number

Is the insurance in Client's name? ❑ No: please enter Insured's information. ❑ Yes.

Insured's Name	Insured's Date of Birth	Gender
Insured's Address	City	State / ZIP
Phone	Relationship (e.g., parent, spouse)	
Insured's Employer/School	Insured's Social Security Number	

EMERGENCY CONTACT

Name of Relative or Friend	Relationship (e.g., parent, spouse)	
Address	City	State / ZIP
Cell Phone	Other Phone	

INSURANCE ASSIGNEMENT AND RELEASE

The above information is true to the best of my knowledge. I certify that I, and/or my dependents, have insurance coverage with the above-named Company and assign directly to ROBERT J MORETTI PHD & ASSOCIATES all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Furthermore, I authorize ROBERT J MORETTI PHD & ASSOCIATES to use and disclose my health care information to the above-named Insurance Company and its agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature	Date
Responsible Party (if a minor)	Signature of Responsible Party / Date

ROBERT J MORETTI PHD & ASSOCIATES

PRIVACY AND CONFIDENTIALITY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL AND MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE, REVIEW IT CAREFULLY.

In order to provide quality care and comply with the law, we keep a record of the services provided to you, which includes information you share with your therapist. We are required by law to protect the confidentiality of your information and to share with you a notice that explains our legal duties and privacy practices.

USES AND DISCLOSURES

This section explains when we may need to access your record and share information about you with others.

Treatment – We routinely access your record to give you quality services and treatment. Occasionally, your therapist may find it necessary to discuss your psychotherapy with a clinician within our practice.

Generally, information about you is not shared with people outside of our practice. However, if you authorize us in writing, we can communicate with others about you, including for reasons not described in this notice. For instance, you can authorize us to speak with your physician about your medical history. You can always ask us in writing to stop sharing information with others. If it became necessary to consult with a professional colleague outside of our practice, your therapist will not share information that would allow you to be identified without your authorization.

In some cases, however, the **law** requires us to share your information even without your authorization, for instance when you are deemed a risk to your safety or the safety of others, or if a child or elder is being endangered.

Payment - We may share information about you with others to be paid for our services. For instance, we may communicate with your insurance to obtain reimbursements. We may also share information with billing and collection services. In these cases, we will share the minimum necessary to obtain reimbursement.

Health care operations - We may access your record for administrative and legal activities necessary to run our business. For instance, we may access your information to provide customer services and appointment remainders. We may create data sets after removing all identifying information. Finally, we may contact you to tell you about treatment alternatives or other health-related services that may be of interest to you.

YOUR RIGHTS

By sending a written request to your therapist or our privacy officer, you can exercise the following rights.

You can ask us to further restrict how we use or share information about you. However, we are not required to agree to these restrictions. – You can ask us to contact you only at phone numbers or addresses of your choice. – You can ask to look at or receive a copy of your record. – You can ask us not to share information about you with your insurance if you pay out-of-pocket in full for our services. – You can ask us to amend your record by telling us why it is not accurate. – You can request a list of all times we shared with others information about you for reasons other than treatment, payment, or health care operations or without your authorization. Examples of this are reports about child abuse and other disclosures required by law. – You will be informed if we share your information by mistake, unless we establish that it is unlikely that your privacy was compromised. – You can request a paper copy of this notice.

VALIDITY

This notice takes effect **July 26, 2013** and we are required to follow it. We reserve the right to change our privacy notice in the future and to apply the new privacy practices to all information that we maintain. If we change the notice, we will post it in our offices and you may request a copy of it.

QUESTIONS AND COMPLAINTS

For further information about our privacy practices, you can contact your therapist or our privacy officer. If you believe your rights have been violated, you can complain by writing to our privacy officer. In addition, you can file a formal complaint with the Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Ave., Washington, D.C. 20201. We will not retaliate against you if you file a complaint.

PRIVACY OFFICER

Robert J. Moretti, PhD – 65 E. Wacker Pl. Suite 900, Chicago, IL 60601 – Phone 312-884-8317

ACKNOWLEDGMENT OF PRIVACY NOTICE	
I have received and understood this Privacy Notice.	
Client Name	
Signature	Date

OFFICE USE ONLY		
The therapist was unable to obtain the client's signature in acknowledgment of the Privacy Notice.		
Reason	Therapist Signature	Date

Informed Consent and Services Agreement

Psychological Services

In your initial appointment, you can expect to discuss what brought you here. You and your therapist will identify goals for treatment as well as treatment options. If it is determined that your main concerns would be more effectively addressed at a different center, your therapist will assist you in getting connected elsewhere.

Psychotherapy can assist you in resolving personal difficulties and in acquiring the skills to live a more satisfying life. However, some issues have no immediate resolution. Moreover, the process of personal development can be difficult, and you may experience some discomfort during the course of psychotherapy. Psychotherapy is ended when goals have been achieved. However, you may decide to stop at any time. Sessions are 30, 45, or 60 minutes long, as agreed upon.

Rescheduling and Missed Appointments

If you are unable to attend your scheduled appointment, you can cancel it by calling or emailing your therapist no later than noon (12 p.m.) of the day before.

If you do not cancel by noon of the day before, you will be charged a late cancellation fee of $100. Please note that health insurances cannot be billed for a missed appointment. Therefore, you will be personally responsible for the late cancellation fee.

Use of Emails

You may choose to use emails when communicating with your therapist about scheduling issues, such as rescheduling an appointment. Emails should not be used to communicate about emergencies or crises. Please note that emails could be accessed by unauthorized people and hence confidentiality cannot be guaranteed.

LATE CANCELLATION FEE	
I understand that if I do not cancel an appointment by noon of the day before, I will be personally responsible for the late cancellation fee of $100.	
Initials	
MEDICARE	
Even if you do not plan on using Medicare for our services, you are required to disclose if you are covered by Medicare.	
❑ Yes, I am covered by Medicare. ❑ No.	
Initials	
ACKNOWLEDGMENT	
I understand this Informed Consent and Services Agreement and agree to its terms. I understand that services may be suspended or terminated if this agreement is not kept.	
Name	
Signature	Date

ROBERT J MORETTI PHD & ASSOCIATES

PAYMENT AGREEMENT

FEES AND PAYMENTS

The fee for psychotherapy sessions is discussed with your therapist. Payment is due at the time of service.

If we are in-network providers ("Preferred Providers") for your insurance plan, you will be responsible to pay your co-payment at the time of service, and we will bill your insurance for the balance.

You are responsible for all charges not paid by your insurance, including deductibles and fees for missed appointments. If you are unsure about your coverage or whether pre-authorization is required, please call the customer service number on the back of your insurance card.

If you have questions about charged amounts, please contact your therapist to receive and review a complete billing statement. Likewise, contact your therapist if you were to experience financial hardship, so that alternative payment arrangements can be made.

While we prefer payments by cash or check, we also accept MasterCard, Visa, Discover, American Express, and bank debit cards. The transaction will be listed on your bank statement as SQ*R.J.MORETTI.

CREDIT CARD ON FILE

Your credit card information will be kept on file and charged only in the following instances:

1) Your insurance does not make a payment to us within sixty days of our billing, in which case you become responsible for the remaining balance.
2) Your insurance sends you a check for amounts that were due to us.
3) Your insurance makes partial payments for services, in which case we will charge you for the remaining balance (e.g., copay, deductible).
4) Patient responsibility fees are due, such as late cancellation fees.

AUTHORIZATION TO CHARGE CREDIT CARD

I understand this Payment Agreement and agree to its terms. I authorize ROBERT J MORETTI PHD & ASSOCIATES to charge my credit card for any due balance, including late cancellation fees and charges not covered by my insurance.

❑ I prefer not to provide my credit card information. I will pay the full fee by cash or check at the time of service. When my insurance reimburses for services provided, I will receive a refund.

❑ I prefer to have statements mailed to me before charging my credit card, so I can have the opportunity to pay by check. If the balance remains unpaid for more than 30 days, it will be charged to the credit card listed below, unless alternative payment arrangements have been agreed upon.

Client Name

Cardholder's Name (if different)

Card Type ❑ Visa ❑ MasterCard ❑ American Express ❑ Discover

Card Number

Expiration Date (MM/YY) /

ZIP Code of Billing Address

Card Verification Code (3-digit on the back of most cards, 4-digit on the front of American Express)

Signature Date