IRENE DASHIELL, LCSW.
31 Oak Street, Suite 14
Patchogue, NY 11772
Phone number (631)289-8765, Fax number (631)447-9717

Consent to use and disclose your health information

This consent is an agreement between you, ___________________________ and Irene Dashiell, LCSW. (Client's Name)

When I diagnose, treat, or refer you, I will be collecting what the law calls Protected Health Information (PHI) about you. I need to use this information to decide on what treatment is best for you and to provide treatment for you. I may also share this information with others who provide treatment for you or need it to arrange for treatment reimbursement.

By signing this form, you are agreeing to let me use your information and send it to others. The Notice of Privacy Practices explains in more detail about your rights and how I can use and share your information. Please read my Privacy Practices carefully before you sign this Consent Form.

If you do not sign this Consent Form agreeing to what is in my Notice of Privacy Practices I cannot treat you.

If you are concerned about sharing some of your information, you have the right to ask me not to use or share some of your information for treatment, payment or administrative purposes. You will have to tell me what you want in writing. Although, I will try to respect your wishes, I am not required to agree to these limitations. However, if I do agree, I promise to comply with your wishes.

After you have signed this consent, you have the right to revoke it (by writing a letter telling me you no longer consent) and I will comply with your wishes about using or sharing your information from that time on. I may already have used or shared some of your information and cannot change what has occurred in the past.

Please be aware by signing this Consent Form you are acknowledging you have received, read and understood my Notice of Privacy Practices.

_______________________________________ ____________________
Signature of Client Date

_______________________________________ ____________________
Print Name of Client Date

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Adult Insurance Form

Name ______________________________ Today's Date ____________

Date of Birth ___/_____/_____ Relationship to the Insured Person ___________

Home Address ______________________________ City ___________ State ________

Zip Code ___________ Home Phone ____________________

Insurance Name ________________________________

Insurance I.D. Number ____________________________

Insurance Group Number (if relevant) ____________________________________

Insured's Name ________________________________

Insured's Date of Birth ___/____/______

Insured's Home Address ____

City ____________ State __________ Zip Code ___________ Home Phone _________

Insured's Employer ____________________________

Is There Another Insurance Plan? Yes_______ NO _________

Second Insurance Name (if relevant) _______________________________________

Second Insurance I.D. Number (if relevant) ____________________________

Second Insurance Group Number (if relevant) ____________________________

Second Insured's Name (if relevant) ______________________________

Second Insured's Date of Birth (if relevant) ___/____/_____

Second Insured's Home Address (if relevant) _______________________________

City ____________ State ____________ Zip code_________ Home Phone _________

Second Insured's Employer (if relevant) _______________________________

Relationship to Second Insured Person (if relevant) ______________________

I Authorize Irene Dashiell, LCSW. to receive payment of medical benefits for the services she provides for me.

__________________________________ ________________
Signature of Client Date

_________________________________ __________________
Print Name of Client Date

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Adult Intake Form

Name ________________________________ Today's Date ___________

Date of Birth ____/_____/______ Age _______

Address _______________________________ City ___________ State ________

Zip Code ___________ Home Phone ____________________

Occupation ________________ Employer ________________________

Work Phone ______________________ Cell Phone ________________

E–mail Address ___________________________

Referral Information:

Name of referral agency or person __________________________________

Address ________________________________ City _____________ State _______

Zip code ___________ Phone _________________

Why is treatment needed now? ______________________________________

Prior Treatment Information:

Have you received prior treatment? Yes_____ No_____

Name of agency or person ____

Address _________________________ City ________ State __________

Zip code ______________ Phone __________________

Dates of treatment ________________________________

Why was treatment needed? ___________________________________

Medical Information:

Do you have any medical problems? Yes ________ No _________

Are you taking any medication? Yes ________ No __________

Name of medication & dosage ___________________________________

Name of Physician ____________________________

Address _______________________________ City ____________ State __________

Zip code _____________ Phone ____________________

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I hereby authorize Irene Dashiell, LCSW. to contact me concerning my appointment at one or more of the following places.

Under HIPAA, you have the right to request how I communicate with you and that our communication method is confidential. I will approve your request if in my opinion it is reasonable. Once I agree to your request, I am obligated to honor it, except if an emergency arises.

I wish to be contacted as follows: (check all that apply)

At my home phone number: ___________________________

___You can leave a message with detailed information
___Leave a message with a call - back number only
___ Call only at specified times of the day ______________________

At my work phone number: __________________________

___You can leave a message with detailed information
___Leave a message with a call - back number only
___Call only at specified times of the day ______________________

At my cell phone number: _____________________________

___You can leave a message with detailed information
___Leave a message with a call - back number only
___Call only at specified times of the day ______________________

___________________________________ _______________
Signature of Client Date

_________________________________ _______________
Print Name of Client Date

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Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU OR YOUR CHILD MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

My commitment to you or your child's privacy

My practice is dedicated to maintaining privacy for you or your child's personal health information. I am required by law to do this. These laws are complicated, but I must provide you with important information.

I will use the information about you or your child's health, which I get from you or from other people mainly to provide **treatment** and to arrange **payment** for my services or for some other business activities, which are called, in the law, **Healthcare Operations.** After you have read this NPP I will ask you to sign a **Consent Form** to let me use and share your or your child's information. If you do not consent and sign this form, I cannot treat you or your child.

If you or I want to use or disclose (send, share or release) information about you or your child for any other purpose I will discuss this with you and ask you to sign an Authorization to allow this.

Of course I will keep your or your child's health information private, but there are some times when the law requires me to use or share it such as:

- **A.** When there is a serious threat to you or your child's health and the safety or the health and safety of another individual or the public. I will only share information with a person or organization that is able to help prevent or reduce the threat.
- **B.** Some lawsuits and legal or court proceedings.

C. If a law enforcement official requires me to do so.

D. For Workers Compensation and similar benefit programs.

Your rights regarding your or your child's health information

A. You can ask me to communicate with you about you or your child's health and related issues in a particular way or at a certain place. For example, you can ask me to call you at home and not at work to schedule or cancel an appointment. I will try my best to do as you ask.

B. You have the right to ask me to limit what I tell certain individuals involved in your or your child's care or for the payment for you or your child's care such as family members and friends. While I do not have to agree to your request, if I do agree, I will keep our agreement except if it is against the law, or in an emergency, or when the information is necessary to treat you or your child. Please be aware in the situation where parents are separated or divorced, I am required by the law to release health information to each parent who has custody.

C. You have the right to look at the health information I have about you or your child such as your medical and billing records. You can even get a copy of these records but, I may charge you. Speak with me to arrange how to see your or your child's records.

D. If you believe the information in your or your child's record is incorrect or incomplete, you can ask me to make some changes (called amending) to the health information. You have to make this request in writing and send it to me. You must tell me the reasons you want to make the changes.

E. You have the right to a copy of this notice. If I change this NPP, I will give you a new copy of my NPP.

F. You have the right to file a complaint if you believe your or your child's privacy rights have been violated. You can file a complaint with me and with the Secretary of the Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the healthcare I provide to you or your child in any way.

If you have any questions regarding this notice or my health information privacy policies, please ask in person or reach my office at (631) 289-8765.

The effective date of this notice is May, 2019