Pica & Associates

Psychological Services
and
Holistic Medicine

Review & Consent Form

Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form and are kept properly confidential. This act gives you, the patient, the right to understand and control how your health information is used. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

Treatment means providing, coordinating, or managing health care and related services by one or more health care providers.

Payment means such activities as obtaining reimbursement for services, confirming coverage and billing or collection activities.

Health Care Operations include the business aspects of running our practice.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

• You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to your doctor.
• The right to request restrictions on disclosures of protected health information. We are, however, not required to agree to a requested restriction.
• If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
• The right to inspect and copy your protected health information.
• The right to amend your protected health information.
• The right to receive an accounting of disclosures of protected health information.
• The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 15, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office, or with the Department of Health & Human Services, Office of Civil rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint. Please contact us for more information. For more information about HIPPA or to file a complaint: The U.S. Department of Health & Human Services, Office of Civil Rights, 200 Independence Avenue, SW, Washington, D.C. 20201 (202) 619-0257

Dr. Pica	(630) 549-6497	pica@picaassoc.net	Dr. Werneke	(630) 421-7260	cwerneke@aol.com
Dr. Gluzerman	(630) 549-6497	gluzerman@picaassoc.net	Dr. Pappas	(630) 549-6497	pappas@picaassoc.net
Dr. Maravelias	(630) 549-6497	maravelias@picaassoc.net	Ms. Creighton	(630) 549-6497	creighton@picaassoc.net
Dr. Shalayska	(630) 549-6497	shalayska@picaassoc.net	Ms. Mazurkiewicz	(630) 549-6497	mazurkiewicz@picaassoc.net

If you wish to discuss your concerns, please leave your phone number and we will contact you. By leaving an e-mail or voice-mail message, you are under no obligation, but we will be happy to discuss ways in which we might be helpful to you. Please do not include confidential information if using email.

Pica & Associates (Psychological Services)

Michael Pica, Psy. D.	Anastasia Maravelias, Psy. D., Licensed Eligible Psychologist
Tanya Gluzerman, Psy. D.	Morgan Pappas, Psy. D., Clinical Psychology Post-Doctoral Fellow
Carolyn Werneke, Ed. S., Psy. D.	Christine Creighton, MS, LCPC, ATR-BC
Olesia Shalayska, Psy. D., CDP	Clare Mazurkiewicz, LPC, ATR

For Your Review and Consent

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: Conduct, plan, and direct my treatment. Obtain payment from third party payers.

I am aware that I have been given a more complete description of the uses and disclosures of my health information. I have been given the rights to review the Notice of Privacy Practices prior to signing the consent. I understand that Dr. Pica, Dr. Gluzerman, Dr. Shalayska, Dr. Maravelias, Dr. Pappas, Dr. Werneke, Ms. Mazurkiewicz, and/or Ms. Creighton has the right to change their Notice of Privacy Practices from time to time and that I may contact them to obtain a current copy of the notice. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

I understand I may revoke this consent in writing at any time, except to the extent that you have taken actions relying on this consent.

I give Pica & Associates permission to leave confidential information via voicemail mail?

Phone numbers- (___) ____-_____ (___) ____-_____ (___) ____-_____

I give Pica & Associates permission to leave confidential information via email?

Email-_____ For what purposes: _____ Not for: _____

I give Pica and Associates permission to leave confidential information via text message?

Phone Number(s) - (___) ____-_____ (___) ____-_____

For what purposes: _____Not for: _____

I understand that although my insurance may pay a portion of the cost of the professional services received in this office, I am ultimately responsible for complete payment of the charges. I will pay at the session or follow another payment plan negotiated with Dr. Pica, Dr. Gluzerman, Dr. Shalayska, Dr. Maravelias, Dr. Pappas, Dr. Werneke, Ms. Mazurkiewicz, and/or Ms. Creighton

I understand that should I, at any time due the course of treatment need to cancel or change an appointment time, I will need to do so within 24 hours of the appointment time, unless an emergency situation arises or I will be charged for the missed appointment, since it has been reserved for me and, without sufficient notice, is unavailable to anyone else.

By signing below I agree I have read and agree to the above.

Signature Responsible Party (if different than client)

Date