DEBALZO, ELGUDIN, LEVINE, RISEN LLC

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Welcome to DeBalzo, Elgudin, Levine, Risen LLC or DELR!

At DELR, we are committed to providing you with the highest quality of care and services. In order to streamline your first visit experience with us, please complete the registration forms and requirements that are listed below.

To comply with federal and state law and to allow billing of insurance, the forms and requirements **MUST** be completed, signed, and returned as soon as possible and prior to your scheduled appointment.

The forms/requirements are:

a. Patient Registration Form
b. Insurance & Financial Information
c. HIPAA- Notice of Privacy Practices
d. Consent for Purposes of Treatment
e. Consent for Treatment of a Minor, if applicable
f. Telehealth Disclosure Statement
g. Copy of BOTH sides of insurance card (if using)
h. Copy of Driver's License (preferred) of Photo Identification

For your convenience, a Credit Card Authorization is included in the Insurance and Financial Information Form above, that you may complete. Your credit card information is kept confidential, is securely stored electronically, and used for balances after insurance has made payment, for copays or for non-insured services.

The completed forms/requirements can ve returned to our front desk via:

- Email to info@delrllc.com
- FAX 216-831-4306
- Please add "New Patient Registration Forms" in the subject line to expedite processing.

Feel free to contact our front desk at 216-831-2900 ext.10 if you have any questions.

Thank you and we look forward to meeting you.

Larissa ELgudin, MD
Linda M DeBalzo, MSN, CNS

DEBALZO, ELGUDIN, LEVINE, RISEN LLC (DELR)

PATIENT REGISTRATION

PATIENT INFORMATION

Legal Name: _____ Legal Sex: _____
Preferred Name: _____ Preferred Pronoun: _____
Street: _____ City: _____
State: _____ Zip: _____ Email: _____
Phone - Home: _____ Cell: _____
Employer: _____ Work phone: _____
Birth Date: _____ Marital Status: _____ Referred by _____

**Please check where we may send an APPOINTMENT REMINDER: ____text, ____email

**Please check where we may leave a VOICEMAIL: ____home, ____office, ____cell

Preferred Pharmacy: Name: _____
Street: _____ City/State: _____ Phone: _____

Guarantor (the person responsible for paying the bill if other than self):

Name: _____ Birth Date: _____ Relation to Patient: _____
Street: _____ City: _____ State: _____ Zip: _____
Email: _____ Phone - Home: _____ Cell: _____

Insurance Information

Primary Insurance: _____

Secondary Insurance: _____

CHECK ONE: ____Copy of Insurance card attached; ____ Self pay

INSURANCE ASSIGNMENT & RELEASE:
I HEREBY ASSIGN MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO DEBALZO, ELGUDIN, LEVINE, RISEN LLC. I ASSUME FINANCIAL RESPONSIBILITY FOR SERVICES NOT COVERED BY INSURANCE. I AUTHORIZE DEBALZO, ELGUDIN, LEVINE, RISEN LLC TO RELEASE DIAGNOSTIC AND TREATMENT INFORMATION TO MY INSURANCE COMPANY.

Patient Name (Print): _____

Patient Signature: _____

Date: _____

DEBALZO, ELGUDIN, LEVINE, RISEN LLC (DELR)

INSURANCE & FINANCIAL INFORMATION

Our staff at DeBalzo, Elgudin, Levine, Risen LLC or DELR, is committed to providing you with the highest quality of care possible and, if you have medical insurance, to helping you receive your maximum allowable benefits. In order to accomplish this, we need your assistance including your understanding of our payment practices and policies as well as of your individual insurance plan.

METHODS OF PAYMENT & MONTHLY STATEMENT

Payment in full for service is requested at the time of your visit. If the clinician you are seeing is a provider for your insurance, then co-payments are required at the time of service. For your convenience, we accept cash, checks, VISA, American Express, Discover, and MasterCard. Returned checks are subject to a $40 fee. If you have an outstanding balance, you will receive monthly statements via email until your balance is paid in full. Any reimbursement from your insurance company is credited to your account for your next visit or a refund check will be sent to you. In special cases, individual payment plans may be arranged at the discretion of your clinician.

CREDIT CARD ON FILE

We offer the service of having a credit card on file, including an HSA/FSA card, as a convenient payment method for balances after insurance has made payment, for non-insured charges or HSA/FSA applicable services. Your credit card information is kept confidential and securely stored electronically. Upon request, a receipt may be given or mailed to you after any charge has been made to your HSA/FSA card or your credit/debit card on file. Please complete the Agreement below if you would like us to provide you with this service.

FILING OF INSURANCE CLAIMS

We file your insurance claims for you, providing that you complete and sign your Patient Registration Form and provide a copy of the front and back of your insurance card(s). While we offer this, we must emphasize that your insurance is a contract between you and your insurance company. We are not a party to that contract, and all charges are your responsibility. We will make every effort to investigate and to try and solve any problems with your insurance but expect that you will take the primary role in ensuring that your account balance is paid in full.

OUR RECOMMENDATIONS

We recommend that you educate yourself about the specifics of your insurance policy. To help you understand your coverage with us, we suggest you call your insurer and ask the following questions:

1. Do I have outpatient mental health benefits?
2. May I choose a provider on my own?
3. What are my benefits if I don't choose a "network" provider?
4. What is my deductible?
5. What is my co-payment yearly, and lifetime maximum?

Knowing the answers to these questions will help you optimize your benefits and your health care.

DEBALZO, ELGUDIN, LEVINE, RISEN LLC (DELR)

NOTICE OF PRIVACY PRACTICES (NPP) – BRIEF VERSION

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.

DELR's commitment to your privacy

Our practice is dedicated to maintaining the privacy of your personal health information as part of providing professional care. We are also required by law to keep your information private and to give you this Notice of Privacy Practices (NPP) describing our legal duties to protect your privacy. This is the shorter version of the full NPP which you may request at any time.

How DELR May Use or Disclose Your Health Information

We will use the information about you which we get from you or from others mainly to provide you with **treatment** (psychotherapy and medication management), to arrange **payment** for our services (health insurances), and for some other business activities which are called, in the law, **health care operations** (quality assurance activities). After you have read this NPP, we will ask you to sign a **consent form** (Consent For Purposes of Treatment, Payment &Healthcare Operations) to let us use and share your information in these ways. If you do not consent and sign this form, we cannot treat you.

If we want to use or disclose (send, share, or release, receive) your information for any other purposes, we will discuss this with you and ask you to sign an Authorization for Release of Information Form to allow us to do that.

There are some times when the laws require us to use or share your information without requiring your authorization. For example:

1. When there is a serious threat to your or another's health and safety or to the public's health and safety. We will only share information with persons who are able to help prevent or reduce the threat.
2. When we are required to do so by lawsuits and other legal or court proceedings.
3. As required by Federal, State, or Local Law.
4. For workers' compensation and similar benefit programs.

There are some other rare situations. They are described in the longer version of the notice of privacy practices.

Your Individual Health Information Rights

1. You can ask us to communicate with you about your health and related issues in a particular way or at a certain place which is more private for you. For example, you can ask us to call you at home, and not at work to schedule or cancel an appointment. We will try our best to do as you ask.

2. You can ask us to limit what we tell people involved in your care or the payment for your care, such as family members and friends. While we don't have to agree to your request, if we do agree, we will keep our agreement except if it is against the law, or an emergency, or when the information is necessary to treat you.
3. You have the right to look at the health information we have about you, such as your medical and billing records. You may get a copy of these records, but there may be a charge you for it. By law there are some instances that we may deny your request and if so, we will send you a written explanation.
4. If you believe that the information in your records is incorrect or missing something important, you can ask us to make some changes (called amending) to your records to correct the situation. You have to make this request in writing and tell us the reasons you want to make the changes.
5. You have the right to request an accounting of certain disclosures of your personal health information.
6. You have the right to a copy of this NPP. If we make changes, we will post the new version of the NPP in our office, and you can always request a copy.
7. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with the DELR Privacy Officer and with the Secretary of the U.S. Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care we provide to you in any way.
8. In the case of a breach of unsecured protected health information, we will notify you as required by law.

If you have any questions regarding this notice or our health information privacy, please contact the DELR Privacy Officers: Larissa Elgudin, MD or Linda DeBalzo, MSN, CNS at 216-831-2900 ext. 10.

The effective date of this notice is June 1, 2022

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PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

I have received, read, understand, and agree with the DELR Notice of Privacy Practices and have been given an opportunity to review it.

NAME(PRINT): _____

SIGNATURE: _____

DATE: _____

DEBALZO, ELGUDIN, LEVINE, RISEN LLC (DELR)

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT, & HEALTHCARE OPERATIONS

I, _____, a patient of DELR or guardian of a patient of DELR, indicate that:

I have read, understand, and agree to the information and terms in the DELR Notice of Privacy Practices and have received a copy of the Notice of Privacy Practices. (Consent to Privacy Practices Notice),

I authorize DELR and its employees to provide mental health care for me or the patient I am legal guardian for, which may include but is not limited to assessment of my condition, psychotherapy, medication treatment/management, diagnostic testing, group therapy, marital and/or family therapy, psychological testing, counseling and supportive care for mental health or alcohol/drug related conditions. This consent also includes contact and discussion with other healthcare professionals necessary for my care and treatment. **(Consent to Treatment)**

I authorize DELR to furnish information to my identified insurance carrier(s) for any and all medical payment activities. I consent to the use of any operational practices to facilitate insurance payment of my medical claims per the Notice of Privacy Practices. I understand that my medical record includes my demographic information (name, date of birth, social security number, address, marital status), psychiatric and medical diagnoses, type and duration of treatment and that this information is routinely requested and shared with insurance companies as part of the billing process. **(Consent for Release of Information for Payment & Treatment)**

I understand that DELR may refuse to provide services to me if I refuse to sign this consent. I understand that I may revoke this consent at any time and that at that time DELR may refuse to provide further services to me. I understand that if I revoke this consent, the revocation will not take effect until it is received in writing or signature below. (Refusal/Revocation of Consent)

Patient Name (Print)_____

Signature of Patient/Guardian_____Date_____

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REFUSAL/REVOCATION OF CONSENT: As of this date _____, under **no circumstances do I wish any of my personal healthcare information to be shared with others including insurance companies and other healthcare professionals.**

Patient Name (Print)_____

Signature of Patient/Guardian_____Date_____

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TELEHEALTH DISCOSURE STATEMENT

As a patient receiving mental health services through telehealth methods, you understand:

1. This service is provided by technology (including but not limited to video and phone).
2. You may decline telehealth services at any time without jeopardizing your access to future care, services, and benefits.
3. In the event of disruption of internet service, it may be necessary to communicate by other means. If this occurs, your provider will contact you by phone or email.
4. Not all mental health concerns are clinically appropriate for telehealth services. Your provider may recommend the provision of face-to-face services for specific concerns.
5. While we have taken specific privacy and encryption measures to protect the information that will be communicated, the privacy and confidentiality of computer mediated communication cannot be 100% guaranteed.
6. Video sessions are not being recorded or stored.
7. It is your responsibility to maintain privacy on the client end of communication.
8. The laws and professional standards that apply to in-person mental health services also apply to telehealth services.
9. **Telehealth visits should not be used for emergency medical or mental health needs. In emergency situations go to the nearest emergency room, or call 911.**

STATEMENT OF UNDERSTANDING: I have read and fully understand the above statement including the risks of telehealth services and agree to assume those risks.

Name(Print): _____

Signature: _____

Date: _____

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REFILLS AND PRIOR AUTHORIZATIONS OF PRESCRIPTION MEDICATION

There is an administrative charge that is not reimbursed by your insurance for the refill and/or prior authorization of any prescription medication that is not handled during your session with the prescriber..

MISSED APPOINTMENTS

Your appointment is reserved for you only. Should you miss an appointment or cancel with less than a 24-hour notice, you will be charged the full clinician's fee for the appointment. Insurance will not reimburse for missed appointments.

We look forward to working with you!

Name (Print): _____

Signature: _____

Date: _____

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CREDIT CARD AUTHORIZATION

I authorize DeBalzo, Elgudin, Levine, Risen LLC to charge the following for balances after insurance has made payment, for non-insured charges or HSA/FSA applicable services:

____ CREDIT CARD

____ HSA

____ FSA

Patient Name: _____

Cardholder Name: _____

Cardholder Signature: _____ Date: _____