

**Yaacov Jeffrey Kravitz, Ed.D.**  
**8120 Old York Road, Yorktowne Plaza, Suite 315,**  
**Elkins Park, PA 19027      215-635-3011**

In an effort to complete your file with the necessary patient information and signatures, please complete this form

Patient Name \_\_\_\_\_ Sex \_\_\_\_\_ DOB \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Messages may be left at (check any that apply) \_\_\_ Home Phone \_\_\_ work \_\_\_ cell

Marital Status: \_\_\_ Minor \_\_\_ Single \_\_\_ Married \_\_\_ Divorced \_\_\_ Widowed \_\_\_ Separated

Employment: \_\_\_ Full Time \_\_\_ Part Time \_\_\_ Minor \_\_\_ Unemployed \_\_\_ Disability

Employer Name: \_\_\_\_\_

Employer Address \_\_\_\_\_

If Student: \_\_\_ Full Time \_\_\_ Part Time School Name: \_\_\_\_\_

Referred By: \_\_\_\_\_

Family Dr./Pediatrician: \_\_\_\_\_

Emergency Contact Person: \_\_\_\_\_ Phone number \_\_\_\_\_

**Responsible Party** Name: \_\_\_\_\_ DOB \_\_\_\_\_

SS# \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Employer: \_\_\_\_\_ Address: \_\_\_\_\_

**Primary Insurance Information:** Must be completed fully in order to bill Insurance Co.:

Name of Insured: \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Insured's DOB \_\_\_\_\_ Insured's S S# \_\_\_\_\_

Insurance Company Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

ID# \_\_\_\_\_ Group # \_\_\_\_\_ Deductible. \_\_\_\_\_

Are You covered for Out-Patient Psychotherapy: \_\_\_ Yes \_\_\_ No. Max.Benefit Amount \_\_\_\_\_

Are You covered under your: \_\_\_ Basic Plan or \_\_\_\_\_ Major Medical Plan .

**Secondary Insurance Information:**

Name Of Insured: \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Insured's DOB \_\_\_\_\_ Insured's S S# \_\_\_\_\_

Insurance Company Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

ID# \_\_\_\_\_ Group # \_\_\_\_\_ Deductible. \_\_\_\_\_

Are You covered for Out-Patient Psychotherapy: \_\_\_ Yes \_\_\_ No. Max.Benefit Amount \_\_\_\_\_

**PSYCHOTHERAPIST-PATIENT SERVICES AGREEMENT**

Welcome to my practice. This document (the Agreement) contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. A HIPAA Notice of Privacy Practices (the Notice) is attached to this Agreement. It is very important that you read these documents carefully. We can discuss any questions you have about the procedures. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance on it; if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

**PSYCHOLOGICAL SERVICES** Psychotherapy varies depending on the personalities of the psychologist and patient, and the particular problems you are experiencing. There are many different methods I may use to deal with the problems that you hope to address. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home. Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience. Our first few sessions will involve an evaluation of your needs. I will then be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

**TREATMENT SESSIONS** We will usually schedule one 45-minute session (one appointment hour of 45 minutes duration) per week at a time we agree on, although some sessions may be longer or more frequent. If you miss a scheduled appointment, you will be expected to pay a cancellation fee of \$70 for it unless you provide 24 hours advance notice of cancellation. It is important to note that insurance companies do not provide reimbursement for cancelled sessions. This fee will be waived by Dr. Kravitz if he and you agree that the situation was an emergency.

**PROFESSIONAL FEES** My hourly fee for individual therapy is \$130. In addition to weekly appointments, I charge this amount for other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour. Other services include, but are not limited to report writing, telephone conversations lasting longer than 10 minutes, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party. [Because of the difficulty of legal involvement, I charge \$200 per hour for preparation and attendance at any legal proceeding, with a minimum of 4 hours, payable in advance.] Other services are often not eligible for insurance reimbursement and are your responsibility.

**CONTACTING ME** Due to my work schedule, I am often not immediately available by telephone. While I am in my office, I probably will not answer the phone if I am with a patient. When I am unavailable, my telephone is answered by an answering machine that I monitor frequently. I will make every effort to return your call within 24 hours, with the exception of weekends and holidays when calls will be returned on the next work day. If you are difficult to reach, please inform me of some times when you will be available. In serious emergencies only you can call my cell at 267-626-9115. If you are unable to reach me and feel that you can't wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist or psychiatrist on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

**LIMITS ON CONFIDENTIALITY** - Please see the attached Notice of Privacy Practices for details.

**BILLING AND PAYMENTS** You will be expected to pay for each session at the time it is held, unless you have insurance coverage that requires another arrangement. All insurance co-pays or private rate payments must be made at the time of the visit. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or small claims court which will require me to disclose otherwise confidential information. In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. If such legal action is necessary, its costs will be included in the claim.

**INSURANCE REIMBURSEMENT** I will fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of my fees. It is very important that you find out exactly what mental health services your insurance policy covers. If you have questions about the coverage, call your plan administrator. "Managed Health Care" plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. It may be necessary to seek approval for more therapy after a certain number of sessions.

In addition if your insurance carrier denies payment for any reason, you assume responsibility for the cost of the sessions at standard private rates (\$130/per session). This agreement shall remain in effect for one year or throughout the course of treatment, whichever is longer.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS, AND THAT YOU AGREE AND CONSENT TO PARTICIPATE IN BEHAVIORAL HEALTH CARE SERVICES OFFERED AND PROVIDED BY DR. YAACOV J. KRAVITZ. YOUR SIGNATURE ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

I understand that I may revoke this authorization to release information at anytime by written notice to Dr. Kravitz and my insurance carrier.

Name (please print) \_\_\_\_\_ Signature \_\_\_\_\_ Date: \_\_\_\_\_

### NOTICE OF PRIVACY PRACTICES

The law protects the privacy of all communications between a patient and a psychologist. In most situations, I can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. **Your signature on this Agreement provides consent for those activities, as follows:**

- I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The other professionals are also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together. I will note all consultations in your Clinical Record (which is called "PHI" in my Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information).
- You should be aware that I practice with other mental health professionals and that I employ administrative staff. In most cases, I need to share your protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing and quality assurance. All of the mental health professionals are bound by the same rules of confidentiality. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.
- I also may have contracts with accountants, billing services and lawyers. As required by HIPAA, I have a formal business associate contract with these businesses, in which they promise to maintain the confidentiality of this data except as specifically allowed in the contract or otherwise required by law. If you wish, I can provide you with the names of these organizations and/or a blank copy of this contract.
- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.
- If a patient seriously threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her, or to contact family members or others who can help provide protection.
- You should also be aware that your contract with your health insurance company requires that I provide it with information relevant to the services that I provide to you. I am required to provide a clinical diagnosis, and, sometimes, additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record. In such situations, I will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit, if you request it. By signing this Agreement, you agree that I can provide requested information to your carrier.

There are some situations where I am permitted or required to disclose information without either your consent or Authorization:

- If you are involved in a court proceeding and a request is made for information concerning the professional services I provided to you, such information is protected by the psychologist-patient privilege law. I cannot provide any information without your written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.
- If a government agency is requesting the information for health oversight activities, I may be required to provide it for them.
- If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
- If I am treating a patient who files a worker's compensation claim, I may, upon appropriate request, be required to provide otherwise confidential information to your employer.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm and I may have to reveal some information about a patient's treatment. These situations are unusual in my practice.

- If I have reason to believe that a child who I am evaluating or treating is an abused child, the law requires that I file a report with the appropriate government agency, usually the Department of Public Welfare. Once such a report is filed, I may be required to provide additional information.
- If I have reason to believe that an elderly person or other adult is in need of protective services (regarding abuse, neglect, exploitation or abandonment), the law allows me to report this to appropriate authorities, usually the Department of Aging, in the case of an elderly person. Once such a report is filed, I may be required to provide additional information.
- If I believe that one of my patients presents a specific and immediate threat of serious bodily injury regarding a specifically identified or a reasonably identifiable victim and he/she is likely to carry out the threat or intent, I may be required to take protective actions, such as warning the potential victim, contacting the police, or initiating proceedings for hospitalization

If such a situation arises, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and I am not an attorney. In situations where specific advice is required, formal legal advice may be needed.

**PROFESSIONAL RECORDS** You should be aware that, pursuant to HIPAA, I keep information about you in two sets of professional records. One set constitutes your Clinical Record (Protected Health Information). It includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts on your life, your diagnosis, the goals that we set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that I receive from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier. Except in unusual circumstances that involve danger to yourself and others or where information has been supplied to me by others confidentially, or the record makes reference to another person (unless such other person is a health care provider) and I believe that access is reasonably likely to cause substantial harm to such other person, you may examine and/or receive a copy of your Clinical Record if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them in my presence, or have them forwarded to another mental health professional so you can discuss the contents. [I am sometimes willing to conduct this review meeting without charge.] In most circumstances, I am allowed to charge a copying fee of at least \$0.20 per page and for certain other expenses. The exceptions to this policy are contained in the attached Notice Form. If I refuse your request for access to your records, you have a right of review (except for information supplied to me confidentially by others), which I will discuss with you upon request.

In addition, I also keep a set of Psychotherapy Notes. These Notes are for my own use and are designed to assist me in providing you with the best treatment. While the contents of Psychotherapy Notes vary from client to client, they can include the contents of our conversations, my analysis of those conversations, and how they impact on your therapy. They also contain particularly sensitive information that you may reveal to me that is not required to be included in your Clinical Record. These Psychotherapy Notes are kept separate from your Clinical Record. Your Psychotherapy Notes are not available to you and cannot be sent to anyone else, including insurance companies without your written, signed Authorization. Insurance companies cannot require your authorization as a condition of coverage nor penalize you in any way for your refusal to provide it.

**PATIENT RIGHTS** HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and my privacy policies and procedures. I am happy to discuss any of these rights or any complaints with you.

#### **EFFECTIVE DATE and CHANGES TO THIS NOTICE**

This Notice is effective on September 7, 2009.

I may change this notice at any time. If I change this notice I will make the new notice terms effective for all PHI that I maintain, including any information created or received prior to issuing the new notice. If I change this notice I will post the revised notice on my web site ([www.dr-yjkravitz.com](http://www.dr-yjkravitz.com)). You may also request a written copy. This form is educational only and does not constitute legal advice and covers only federal, not state law.

**Yaacov Jeffrey Kravitz, Ed.D.**  
**8120 Old York Road, Yorktowne Plaza, Suite 315,**  
**Elkins Park, PA 19027      215-635-3011**

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**ACKNOWLEDGEMENT OF RECEIPT OF  
NOTICE OF PRIVACY PRACTICES**

By my signature below I, \_\_\_\_\_, acknowledge that I received a copy of the Notice of Privacy Practices.

\_\_\_\_\_  
Signature of client (or personal representative)

\_\_\_\_\_  
Date

**If this acknowledge is signed by a personal representative on behalf of the client, complete the following:**

Personal Representative's Name: \_\_\_\_\_

Relationship to Client: \_\_\_\_\_

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**CONSENT TO TREATMENT FORM**

**By my signature below , I acknowledge that I received a copy of the Psychotherapist-Patient Agreement indicating that I have been informed of the policies and practices of Dr. Kravitz and that I consent to treatment.**

\_\_\_\_\_  
(Signature/relationship if patient is a minor)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
Please print Name)

\_\_\_\_\_  
(Witness)

\_\_\_\_\_  
Date

**This form will be retained in your medical records**

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**FOR OFFICE USE ONLY**

I attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
  - Communications barriers prohibited obtaining the acknowledgement
  - An emergency situation prevented us from obtaining acknowledgement
  - Other (Please Specify)
-

Authorization To Release Information Form For Insurance Purposes

Patient Name: \_\_\_\_\_ DOB \_\_\_\_\_

Patient Address: \_\_\_\_\_

Information is Being Released To: (Your Insurance Company) \_\_\_\_\_  
\_\_\_\_\_

Specific Information To Be Released: Copy of Intake Report (first page), and Update Summaries of treatment progress, and copies of psychiatric reports.

Purpose for Releasing Information: Establishes reasons for providing insurance coverage of mental health services and for additional authorization of services.

I understand that my records are protected under Section 5100.34 of the Pennsylvania Mental Health Procedures Act and the Pennsylvania Drug and Alcohol Abuse Control Act, and under the federal regulations governing Confidentiality of Drug and Alcohol Abuse Patients Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in state or federal regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

\_\_\_\_\_  
(Specification of date, event, or condition upon which this consent expires)

I, \_\_\_\_\_ hereby authorize Yaacov Jeffrey Kravitz, Ed.D., 8120 Old York Road, Yorktown Plaza Suite 315, Elkins Park, PA 19027 to  
(patient)

release/obtain the information stated above.

Patient \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Person Authorized In Lieu Of Patient \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Relationship To Patient \_\_\_\_\_

Witness \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Prohibition On Redislosure

Drug and Alcohol Abuse information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations (42 CFR Part 2 ) prohibit you from making any further disclosures of it without the specific written consent the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any of the information to criminally investigated prosecute any alcohol or drug abuse patient.

COPY OF RELEASE OFFERED TO PATIENT:    ACCEPTED \_\_\_\_\_ REJECTED \_\_\_\_\_

**CONSENT TO RELEASE INFORMATION TO PRIMARY CARE PHYSICIAN**

Communication between behavioral health providers and your primary care physicians is important to help ensure that you receive comprehensive and quality health care. This information will not be released without your consent. This information may include diagnosis, treatment plan, progress, and medication if necessary. I may revoke this consent at any time except to the extent that the action has been taken in reliance upon it and that in any event this consent shall expire twelve (12) months from the date of signature, unless another date has been specified.

I, \_\_\_\_\_ . For the purpose of  
(patient name-print) (pt D.O.B.) (pt. Social Security #)

coordinating care, authorize Yaacov Jeffrey Kravitz, Ed.D., to release information indicated in the "consent" portion of this form to:

**PCP Name:** \_\_\_\_\_

**PCP Phone:** \_\_\_\_\_ **PCP Fax** \_\_\_\_\_

**PCP Address:** \_\_\_\_\_  
(Street) (City) (State) (Zip)

**Information for PCP**

The patient was seen by me on (date)\_\_\_\_\_ for (Diagnosis): \_\_\_\_\_

Treatment Plan\_\_\_\_\_

Please call me at (215) 635-3011 to discuss this case further or if you need any other information.

\_\_\_\_\_  
(Provider Signature) **Yaacov Jeffrey Kravitz, Ed.D., PA Psychologist, PS 005526L**  
(Provider Name) (Licensure)

**Consent**

I, the undersigned, understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it and that in any event this consent shall expire twelve (12) months from the date of signature, unless another date is specified. I have read and understood the above information and give my consent:

**PATIENT PLEASE CHECK ONE OF THE FOLLOWING !!!!!!!**

- 1) To release any applicable mental health/substance abuse information to my primary care physician.
- 2) To release only medication information to my primary care physician.
- 3) I do not give my consent to releasing any information to my primary care physician.

\_\_\_\_\_  
Patient signature (patients over 18) (Date)

\_\_\_\_\_  
Witness (Date)

**Yaacov Jeffrey Kravitz, Ed.D.**  
**Licensed Psychologist**  
**215-635-3011 (office)**  
**8120 Old York Road**  
**Yorktown Plaza, Suite 315**  
**Elkins Park, PA 19027**  
**Affiliate of Growth Opportunities Center**