

**DR. YAACOV J. KRAVITZ,**  
**affiliate of GROWTH OPPORTUNITY CENTER**

**2910 FRANKS ROAD, SUITE 1, HUNTINGDON VALLEY, PA 19006 [215/947-8654]**

Thank you for your interest in the Growth Opportunity Center. 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 \_\_\_\_\_

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)

Growth Opportunity Center  
2910 Franks Road  
Huntingdon Valley, PA 19006

I, \_\_\_\_\_ hereby authorize Growth Opportunity Center to  
(patient)

release/obtain the information stated above.

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

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

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

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

Prohibition On Redisclosure

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 \_\_\_\_\_

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# GROWTH OPPORTUNITY CENTER

## NOTICE OF PRIVACY PRACTICES

215/947-8654

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**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.**

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We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, legal obligations, and your rights concerning your health information (“Protected Health Information” or “PHI”). We must follow the privacy practices that are described in this Notice (which may be amended from time to time). For more information about our privacy practices, or for additional copies of this Notice, please contact us by using the information listed in Section II G of this Notice.

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### I. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

#### **A. Permissible Uses and Disclosures without Your Written Authorization**

We may use and disclose PHI without your written authorization, excluding Psychotherapy Notes as described in Section II, for certain purposes as described below. The examples provided in each category are not meant to be exhaustive, but instead are meant to describe the types of uses and disclosures that are permissible under federal and state law.

**1. Treatment:** We may use and disclose PHI in order to provide treatment to you. For example, we may use PHI to diagnose and provide counseling service to you. In addition, we may disclose PHI to other health care providers involved in your treatment.

**2. Payment:** We may use or disclose PHI so that services you receive are appropriately billed to, and payment is collected from, your health plan. By way of example, we may disclose PHI to permit your health plan to take certain actions before it approves or pays for treatment services.

**3. Health Care Operations:** We may use and disclose PHI in connection with our health care operations, including quality improvement activities, training programs, accreditation, certification, licensing or credentialing activities.

**4. Required or Permitted by Law:** We may use or disclose PHI when we are required or permitted to do so by law. For example, we may disclose PHI to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. In addition, we may disclose PHI to the extent necessary to avert a serious threat to your health or safety or the health or safety of others. Other disclosures permitted or required by law include the following: disclosures for public health activities; health oversight activities including disclosures to state or federal agencies authorized to access PHI; disclosures to judicial and law enforcement officials in response to a court order or other lawful process; disclosures for research when approved by an institutional review board; and disclosures to military or national security agencies, coroners, medical examiners, and correctional institutions or otherwise as authorized by law.

## **B. Uses and Disclosures Requiring Your Written Authorization**

**1. Psychotherapy Notes:** Notes recorded by your clinician documenting the contents of a counseling session with you ("Psychotherapy Notes") will be used only by your clinician and will not otherwise be used or disclosed without your written authorization.

**2. Marketing Communications:** We will not use your health information for marketing communications without your written authorization.

**3. Other Uses and Disclosures:** Uses and disclosures other than those described in Section I.A. above will only be made with your written authorization. For example, you will need to sign an authorization form before we can send PHI to your life insurance company, to a school, or to your attorney. You may revoke any such authorization at any time.

## **II. YOUR INDIVIDUAL RIGHTS**

**A. Right to Inspect and Copy.** You may request access to your medical record and billing records maintained by us in order to inspect and request copies of the records. All requests for access must be made in writing. Under limited circumstances, we may deny access to your records. We may charge a fee for the costs of copying and sending you any records requested. If you are a parent or legal guardian of a minor, please note that certain portions of the minor's medical record may not be accessible to you.

**B. Right to Alternative Communications.** You may request, and we will accommodate, any reasonable written request for you to receive PHI by alternative means of communication or at alternative locations.

**C. Right to Request Restrictions.** You have the right to request a restriction on PHI used for disclosure for treatment, payment or health care operations. You must request any such restriction in writing addressed to the Privacy Officer as indicated below. We are not required to agree to any such restriction you may request.

**D. Right to Accounting of Disclosures.** Upon written request, you may obtain an Accounting of certain disclosures of PHI made by us after April 14, 2003. This right applies to disclosures for purposes other than treatment, payment or health care operations, excludes disclosures made to you or disclosures otherwise authorized by you, and is subject to other restrictions and limitations.

**E. Right to Request Amendment.** You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

**F. Right to Obtain Notice.** You have the right to obtain a paper copy of this Notice by submitting a request to the Privacy Officer at any time.

**G. Questions and Complaints.** If you desire further information about your privacy rights, or are concerned that we have violated your privacy rights, you may contact the **Privacy Officer, Dr. Kenneth Barber** at (215)947-8654. You may also file written complaints with the Director, Officer for Civil Rights of the U.S. Department of Health and Human Services. We will not retaliate against you if you file a complaint with the Director or myself.

## **III. EFFECTIVE DATE AND CHANGES TO THIS NOTICE**

**A. Effective Date.** This Notice is effective on April 14, 2003.

**B. Changes to this Notice.** We may change the terms of this Notice at any time. If we change this Notice, we may make the new notice terms effective for all PHI that we maintain, including any information created or received prior to issuing the new notice. If we change this Notice, we will post the revised notice in the waiting area of our office. You may also obtain any revised notice by contacting the Privacy Officer. *This Form is educational only, does not constitute legal advice, and covers only federal, not state, law.*

PATIENT COPY

Yaacov J. Kravitz, Ed.D.  
Affiliate of  
GROWTH OPPORTUNITY CENTER  
(215) 947-8654  
Information for Clients

Welcome to the Growth Opportunity Center. It is our goal to assist you with the problems that you may be currently experiencing. Please read the following information carefully.

Psychological Services

Psychotherapy is not easily described in general statements. It varies depending on both the therapist and the patient and the particular problems, which the patient brings to therapy. There are a number of different approaches, which can be utilized to address the problems you hope to improve. It requires a very active effort on your part. In order to be most successful, you will have to work both during sessions and at home.

Psychotherapy has both benefits and risks. Risks sometimes include experiencing uncomfortable levels of feelings like sadness, guilt and anxiety, anger and frustration, loneliness and helplessness. Psychotherapy often requires recalling unpleasant aspects of your history. Psychotherapy has also been shown to have benefits for people who undertake it. It often leads to significant reduction in feelings of distress, better relationships and resolution of specific problems, but there are no guarantees that this will happen.

By the end of the initial session, your therapist will be able to offer you some initial impressions of what your treatment will include and an initial treatment plan, if you decide to continue. In some cases, particularly with children, the initial evaluation will take several sessions. You should consider this information along with your own assessment about whether your therapist is a person with whom you feel comfortable working. Therapy involves a large commitment of time, money and energy. Psychiatric consultation for medication may be recommended. If you have questions about your treatment, diagnosis, or sessions, you should discuss them with your therapist whenever they arise. If you are unable to discuss your concerns with your therapist, you may call and ask to speak with the Clinical Director.

Treatment Sessions

Each therapy session will be approximately 45 minutes in length. Please be aware that your therapist will make every effort to be available to you at your appointment time. Because this time could have been available to another person, we will expect you to keep any appointment you make unless an emergency occurs or you give 24 hours notice. Please know that the office policy states that you will be charged \$\_\_70\_\_ for the session. Additionally, there will be a \$10.00 charge for any checks returned for insufficient funds.

Contacting the Center

We maintain a voicemail system, which is available to take your messages 24 hours a day. In most cases, non-urgent messages can be left on voice mail to your therapist and will be picked up and returned within a few hours during daytime office hours. Someone in our group will be on call for emergency assistance 24 hours a day, 7 days a week. If an emergency exist, please call our pager, 215/905-2960 and put in your phone number.

Confidentiality

What you discuss with us at the Growth Opportunity Center is strictly confidential and is protected both by law and our professional codes of ethics. We can only release information outside of the Center with your

written consent. There are, however, certain limits to confidentiality. We are obligated to share information given to us in confidence if we have reason to believe that a client is (1) likely to inflict bodily harm on someone else (2) likely to harm himself or herself, or (3) suspected of, or involved in child abuse. A court can demand us to testify when there is just cause as deemed by a judge. Other legal proceedings (such as workmen's compensation claims, criminal proceedings, competency hearings, etc.) as well as your submission of a claim to your insurance company may require us to release information. At a minimum, your diagnosis and appointment dates will go to your insurance company if you choose to use insurance. Managed care and EAP plans may require us to submit more details than diagnosis alone.

All of our staff works as a team to provide quality care. We consult with each other to provide the best treatment. If you see more than one of our professional staff, they will communicate with each other to coordinate your care. If other members of your family are in treatment with us, the therapists involved will share relevant information with each other only with your permission. We would be happy to clarify any questions you have about confidentiality and its limits, including how it varies when the patient is a minor (under 18 years of age).

Payment for Service

If you have insurance that covers mental health and we are in your insurance network, the Center will help make necessary arrangements to bill for your services, which most often involves a co-payment from you. If you don't have insurance, which will cover services, payment arrangements based on your income can be made, with fee adjustment possible in circumstances of financial hardship.

If there are co-payments required by your insurance plan, co-payment fees are as follows:

Visits \_\_\_\_\_ to \_\_\_\_\_ \$ \_\_\_\_\_ Co-Pay  
Visits \_\_\_\_\_ to \_\_\_\_\_ \$ \_\_\_\_\_ Co-Pay  
Visits \_\_\_\_\_ to \_\_\_\_\_ \$ \_\_\_\_\_ Co-Pay

**Consent to Treatment Form**

By my signature below, I acknowledge that I received a copy of the Client Information Form, indicating that I have been informed of the policies regarding our Center and that I consent to treatment.

\_\_\_\_\_  
(Signature/relationship if patient is a minor)      (Date)      (Please Print Name)

\_\_\_\_\_  
(Witness)      (Date)

# GROWTH OPPORTUNITY CENTER

(215) 947-8654

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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 for Growth Opportunity Center.

\_\_\_\_\_  
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 Client Information Form, indicating that I have been informed of the policies of our Center 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)
-



# Growth Opportunity Center

## Statement of Members' Responsibilities

### Statement of Members' Rights

- Members have the right to be treated with dignity and respect
- Members have the right to fair treatment; regardless of their race, religion, gender, ethnicity, age, disability, or source of payment.
- Members have the right to have their treatment and other member information kept private. Only where permitted by law, may records be released without member permission
- Members have the right to easily access timely care in a timely fashion.
- Members have the right to know about their treatment choices. This is regardless of cost or coverage by the member's benefit plan.
- Members have the right to share in developing their plan of care.
- Members have the right to information in a language they can understand.
- Members have the right to have a clear explanation of their condition and treatment options.
- Members have the right to information about their insurance, its practitioners, services and role in the treatment process.
- Members have the right to information about clinical guidelines used in providing and managing their care.
- Members have the right to ask their provider about their work history and training.
- Members have to right to give input on the Members' Rights and Responsibilities policy.
- Members have a right to know about advocacy and community groups and prevention services.
- Members have a right to freely file a complaint or appeal and to learn how to do so.
- Members have the right to know of their rights and responsibilities in the treatment process.
- Members have the right to receive services that will not jeopardize their employment.
- Members have the right to list certain preferences in a provider.

- Members have the responsibility to treat those giving them care with dignity and respect.
- Members have the responsibility to give providers information they need. This is so providers can deliver the best possible care.
- Members have the responsibility to ask questions about their care. This is to help them understand their care.
- Members have responsibilities to follow the treatment plan. The plan of care is to be agreed upon by the member and provider.
- Members have responsibility to follow the agreed upon medication plan.
- Members have the responsibility to tell their provider and primary care physician about medication changes, including medications given to them by others.
- Members have responsibility to keep their appointments. Members should call their providers as soon as they know they need to cancel visits.
- Members have the responsibility to let their provider know when the treatment plan isn't working for them.
- Members have the responsibility to let their provider know about problems with paying fees.
- Members have the responsibility to report abuse and fraud.
- Members have the responsibility to openly report concerns about the quality of care they receive.

*My signature below shows that I have been informed of my rights and responsibilities, and that I understand this information.*

\_\_\_\_\_  
**Member signature** **Date**

*The signature below shows that I have explained this statement to the patient. I have offered the member a copy of this form.*

\_\_\_\_\_  
**Provider signature** **Date**

**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**