Dr. Yaacov J. Kravitz

Affiliate of Growth Opportunity Center, 928 Jaymor Rd., Southampton, PA 18966

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_____

* Confidential messages may be left at (check any that apply) ___ Home Phone __work ____cell
* If you consent to the exchange of logistic information (eg, appointments) and educational information by e-mail please give your e-mail address _____ Initials ____
PLEASE NOTE THAT E-MAIL IS NOT SECURE AND I CAN NOT GUARANTEE ITS CONFIDENTIALITY.

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_____

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: Are You covered for Out-Patient Psychotherapy:___Yes___No

Name Of Insured: _____Relationship to Patient_____

Insured's DOB_____ _____

Insurance Company Name _____Phone_____

Address _____

ID# _____Group # _____Deductible._____

Name_____ INTAKE QUESTIONNAIRE
Date _____ Yaacov Jeffrey Kravitz, Ed.D., Licensed Psychologist

Please complete these questions as fully and as accurately as you can. Case records are strictly confidential.

I. PERSONAL INFORMATION

Birth date: ____/_____/_____ Age:___ Sex____ Race_____

Religion_____ Church/Synagogue member: yes __ no __

Education: Years or grade completed_____ Degrees earned_____

Occupation_____ How long in present job?_____

Have you had any counseling and/or psychiatric care? yes[ ] No[ ] If yes, when and under what circumstances:

Name of Dr. or counselor	Approximate Dates	What problem were you treated for?		

Who referred you to this psychologist or this group? _____

IN EMERGENCY PLEASE NOTIFY:

Name_____ Relationship _____Phone _____

Address_____Zip_____

MARITAL INFORMATION

Present Marital Status: (check one): single [ ] engaged [ ] married [ ]
separated [ ] divorced [ ] widowed [ ] unmarried couple [ ]

How long in present status?_____

Present mate: First name_____ Age _____

Occupation_____ religion_____ Hobbies _____

Comments about mate _____

_____

Prior marriage length was _____years. From 19____ to 19____

Prior mate: First name_____

Occupation _____ religion_____ Hobbies_____

(comments about mate _____

Was this marriage broken by divorce [ ] or by the death [ ] of mate?

Give information about additional marriages on the reverse side of page.

CHILDREN:

First name: Sex Age Descriptive comments

_____ ___ ___ _____

_____ ___ ___ _____

_____ ___ ___ _____

_____ ___ ___ _____

_____ ___ ___ _____

Who is currently living in your household? _____

_____

Name_____ INTAKE QUESTIONNAIRE
Date _____ Yaacov Jeffrey Kravitz, Ed.D., Licensed Psychologist

FAMILY HISTORY

Parents (names) Mother _____ Father _____
Occupation_____ _____
Education _____ _____
Religion_____ _____
How do you get along? _____ _____
Parent's current marital status _____ _____
Current age or age at death _____ _____
If deceased, what was your age then? _____ _____
Comments _____ _____

Sisters and brothers in chronological order (include yourself)

First name Sex Age Descriptive comments

_____ ___ ___ _____
_____ ___ ___ _____
_____ ___ ___ _____
_____ ___ ___ _____

Give any other information about your family that seems important (include suicide, chemical abuse, diagnosed mental illness, etc.) _____
_____
_____

Is there any history of abuse in your life? Yes [ ] No [ ]
If yes, was it verbal [ ] emotional [ ] physical [ ] sexual [ ]

II. GENERAL CURRENT HEALTH data.

1) How much caffeine do you consume each day? (Give number of cups, size of typical cup, and amount of sugar per cup)
Coffee ___ cups _____ Oz/CUP _____ sugar
tea _____ cups _____ Oz/CUP _____ sugar
sodas/colas_____ Type _____

2) Cigarette use per day equals _____ cigarettes, or _____ packages.

a) Alcohol and drug consumption equals

Substance	Amount	How often ?	Age began	Last used
Wine				
Beer				
Hard liquor				
Drug(specify)				

4) List all known allergies (food, medications, environmental factors) including the reactions you experience. Please include any treatment and/or medications that you use to deal with your allergies:

5) What kind of exercise do you get? What is the frequency of your exercise?

What is the effect on you of this exercise?

How is most of your free time occupied?

6) What is your current height?_____Weight_____
In the last six months have you gained ___ weight or lost_ weight?
How much? ____ lbs. Reason

7) Describe your daily diet. Include foods, drinks, snacks:
Breakfast:

Lunch:

Dinner:

Snacks:

8) Please list any medical conditions that you have now or have had in the past:

Medical Condition	Approximate Dates	Name of Dr. or counselor

9)List all medications you currently take. Please include dosage and condition being treated.
Please list all current medications (prescription/non-prescription/vitamins/herbs/other):

Name of medication	Dosage	Date started	What is it for?

What is the date of your last physical exam?_____

III. INFORMATION ABOUT CURRENT CONCERNS
Why did you choose this time to seek counseling?

Has life been satisfying to you? Explain.

Additional thoughts or comments:

Name_____Date: _____

Below is a list of the ways you might have felt or behaved. Please check the boxes to tell me how often you have felt this way in the past week or so	Not at all	Less than 1 day/ Week	1-2 days this week	3-4 days this week	5-7 days this week	Nearly every day for 2 weeks	Do not write in this column
1. My appetite was poor.							
2. I could not shake off the blues.							
3. I had trouble keeping my mind on what I was doing.							
4. I felt depressed							
5. My sleep was restless							
6. I felt sad.							
7. I could not get going.							
8. Nothing made me happy							
9. I felt like a bad person							
10. I lost interest in my usual activities							
11. I slept much more than usual.							
12. I felt like I was moving too slowly.							
13. I felt fidgety.							
14. I wished I were dead							
15. I wanted to hurt myself							
16. I was tired all the time							
17. I did not like myself							
18. I lost a lot of weight without trying to.							
19. I had a lot of trouble getting to sleep							
20. I could not focus on the important things.							
21. Feeling nervous, anxious, or on edge .							
22. Not being able to stop or control worrying .							
23. Worrying too much about different things							
24 Trouble relaxing .							
25. Being so restless that it's hard to sit still							
26. Becoming easily annoyed or irritable							
27. Feeling afraid as if something awful might happen							
28. Panic attacks							
29. Hearing voices							
30. Inability to control thoughts							
31. Can't make decisions							
32. Difficulty concentrating							
33. Racing thoughts							
34. Stomach problems							
35. Binge eating							
36. Pain							
37. Periods of confusion or disorientation							
38. Memory lapses, forgetfulness							
39. Thoughts of loss or trauma							
40. Fear of going crazy or out of control							

YAACOV J. KRAVITZ, Ed.D.
Licensed Psychologist

101 Greenwood Ave. Suite 410
Jenkintown, PA 19046-2603

drk@dr-yjkravitz.com
215-635-3O11

Office Information

My office is located at
101 Greenwood Ave.
Suite 410
Jenkintown, PA 19046-2603

My business phone number: 215-635-3011.

Office Hours are by appointment only:
Monday: 10:00am -7:00pm; Tuesday 10:00am - 7:00pm ; Thursday 10:00am -5:00pm

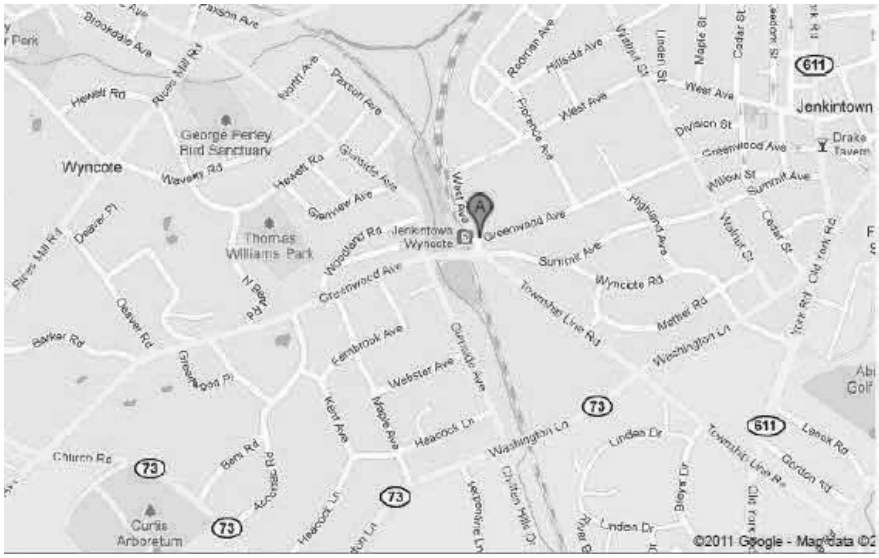
Directions and parking:

101 Greenwood Ave. is located at the intersection of Greenwood Ave., West Ave. and Township Line Road in Jenkintown. We are directly across the street from the SEPTA Regional Rail – Jenkintown Station.

There is a large parking lot on the east side of the building with direct access to the building. Please use the upper level.

There are parking spaces for individuals with disability tags in three locations:

1. off of Greenwood Ave at the corner of the building near the entrance to the lot
2. one space behind the building
3. three spaces on the parking lot level (no wheel chair access on this level).



YAACOV J. KRAVITZ, Ed.D.,Licensed Psychologist
101 Greenwood Ave., Suite 410, Jenkintown, PA 19046 www.dr-yjkravitz.com 215-635-3O11

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 for a 45 minute session; $160 for a 60 minute session; and $175 for an initial assessment. I charge $150 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 may 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. 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: _____

Growth Opportunity Center

Acknowledgement for the Receipt of Patient Documents

INFORMED CONSENT TO TREATMENT

Your signature below indicates that you have read the information, understand it, agree to abide by its terms during your professional relationship with GOC and that you have received the Informed Consent for Treatment document.

_____ _____
CLIENT (14 years and older) DATE

_____ _____
PARENT AND/OR GUARDIAN (for clients under 14 and/or for parents with shared legal custody of a minor) RELATIONSHIP TO CLIENT

_____ _____
2nd PARENT (needed for parents with shared legal custody of a minor) RELATIONSHIP TO CLIENT

Note: A parent or parents must sign for children under 14 years old. If you are 14 years or older, you have the right to consent to voluntary treatment on your own.
In shared legal custody situations, consent from both parents to treat a minor child is required. Your therapist will review requirements for parental consent in other custody situations with you

NOTICE OF PRIVACY PRACTICES

Your signature below indicates that you have read the information, understand it, agree to abide by its terms during your professional relationship with GOC and that you have received the Notice of Privacy Practices document.

_____ _____
CLIENT (14 years and older) DATE

_____ _____
PARENT AND/OR GUARDIAN (for clients under 14) RELATIONSHIP TO CLIENT

STATEMENT OF RIGHTS AND RESPONSIBILITIES

Your signature below indicates that you have read the information, understand it, agree to abide by its terms during your professional relationship with GOC and that you have received the Statement of Rights and Responsibilities document.

_____ _____
CLIENT (14 years and older) DATE

_____ _____
PARENT AND/OR GUARDIAN (for clients under 14) RELATIONSHIP TO CLIENT

_____ _____
WITNESS (GOC therapist) DATE

This form will be retained in your medical records

Growth Opportunity Center

AUTHORIZATION TO RELEASE INFORMATION TO PRIMARY CARE PHYSICIAN

Communication between behavioral health providers and your primary care physician 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. You 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 six months from the date of signature, unless another date has been specified.

I, _____, _____ , for the purpose of coordinating care, authorize Growth
(Patient Name) (Patient DOB)
Opportunity Center, to release information indicated in the "consent" portion of this form to:

PCP Name: _____

PCP Phone: _____ PCP Fax:_____

PCP Address: _____

Information for PCP

The patient was seen by me on (date) _____ for (Diagnosis) _____

Treatment Plan: _____

For Psychiatrists Only

The following medication(s) was/will be started _____
_____

___Medication was not indicated ___ Patient Refused Medication ___Psychotherapy suggested before trying Medication

___I recommend the following medical intervention by PCP before initiating Medications:
Medical Work-Up for: _____

Lab Tests for: ___ CBC ___ Thyroid Studies ___ Chem Panel ____ EKG
Other: _____

Please call me at (215) 947-8654 ext. _____, to discuss this case further or if you need any other information.

_____ _____ _____
(Provider Signature) (Provider Name) (Licensure)

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 six months from the date of my signature, unless another date is specified. I have read and understood the above information and give my consent verbally or in writing:

PATIENT: PLEASE CHECK ONE OF THE FOLLOWING:

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

_____ _____ _____ _____
Patient Signature (Patient over 18) Date Parent/Guardian Signature Date

_____ _____
Witness Date

Growth Opportunity Center

Authorization to Release Information Form For Insurance Purposes

Patient's Name:_____ DOB:_____

Patient's
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 Growth Opportunity Center to release the
(Patient)
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_____

Growth Opportunity Center

Authorization to Release Information to a Third Party/Parties

Patient's Name:_____ DOB:_____ AGE:_____

I HEREBY AUTHORIZE GROWTH OPPORTUNITY CENTER, 928 JAYMOR RD, 8150, SOUTHAMPTON, PA 18966 TO DISCLOSE TO/RECEIVE INFORMATION FROM.

_____ _____

(Name of person and or entity) (Relationship to client)

_____

Address and telephone number of the person or entity to whom information will be disclosed.

I UNDERSTAND THAT THIS INFORMATION DISCLOSURE RELEASE WILL BE MADE FOR THE FOLLOWING PURPOSE:

- ☐ Coordination of Treatment
- ☐ Other _____

AND WILL BE LIMITED TO THE FOLLOWING SPECIFIC TYPES OF INFORMATION.

- ☐ Any applicable mental health-related information, including medications (If this box not checked, check all that apply):
- ☐ Appointment scheduling
- ☐ Session attendance
- ☐ Assessment testing reports
- ☐ Billing payment records
- ☐ Other_____

This authorization will expire on (check on):

Six months from date signed below

- ☐ Termination of treatment
- ☐ Other date or specific event_____

- I UNDERSTAND THAT I HAVE THE RIGHT TO REFUSE TO SIGN THIS AUTHORIZATION.
- I UNDERSTAND THAT, AT ANY TIME I HAVE THE RIGHT TO REVOKE THIS PERMISSION TO RELEASE
- INFORMATION. THE REVOCATION CANNOT APPLY TO RELEASES THAT MAY HAVE BEEN MADE PRIOR TO THE REQUEST TO REVOKE INFORMATION.
- I UNDERSTAND THAT THIS INFORMATION IS CONFIDENTIAL AND IS PROTECTED WITHIN THE BOUNDS OF HIPAA LAW FROM DISCLOSURE WITHOUT MY PERMISSION.
- I FURTHER UNDERSTAND THAT RELEASED INFORMATION MAY BE SUBJECT TO REDISCLOSURE BY OTHERS AND MAY THEN NO LONGER BE PROTECTED.

_____ Date_____

CLIENT SIGNATURE (AGE 14 AND OLDER)

_____ Date_____

PARENT OR LEGAL GUARDIAN (FOR ALL CLIENTS UNDER 18; CO-SIGNATURE REQUIRED FOR CLIENTS 14-17)

_____ Date_____

WITNESS (GOC provider or staff)

(For provider or staff only) Copy given to client_____ Copy offered but declined_____

Growth Opportunity Center

PATIENT READ AND KEEP

GROWTH OPPORTUNITY CENTER
215/947-8654
INFORMED CONSENT FOR TREATMENT

Welcome to the Growth Opportunity Center (GOC). This document contains important information about our professional services and business policies. Please read it carefully or ask your therapist to review it with you.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easy to describe in general statements. Therapists use many different methods and approaches, which may vary depending on the therapist and the patient's particular problems/challenges. In addition, therapists vary in terms of their training and education. Therapists at GOC are usually Psychologists (Ph.D. and PsyD), Licensed Clinical Social Workers (LCSW), Licensed Marriage and Family Therapists (LMFT), and Licensed Professional Counselors (LPC). However, GOC also uses unlicensed therapists who are working towards their license or other educational goals. Please discuss with your therapist his or her training, education, and particular therapeutic orientation. Psychotherapy calls for a very active effort on your part. In order for it to be most successful, you will have to commit to time and energy both during and after sessions and keep to your scheduled appointments. Psychotherapy can have benefits and risks. Because it often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. Psychotherapy has also been shown to have benefits, often leading to better relationships, solutions to specific problems, and significant reductions in distress. However, there are no guarantees of what you will experience.

Your first session(s) will involve your therapist getting to know you and evaluating your needs. Subsequently, your therapist will summarize your goals and review an initial treatment plan. You should evaluate this information and determine if you feel comfortable working with your therapist and wish to continue treatment. Your therapist may also recommend a psychiatric consultation for medication; if so, you are free to consider psychiatrists from Growth Opportunity Center or outside practitioners. If you have questions or concerns, you should discuss them whenever they arise. If you ever feel unable to discuss concerns with your therapist, you may ask to speak with the Executive Director or her/his representative.

TREATMENT SESSIONS

Treatment sessions are normally 45 or 50 minutes in length and may be scheduled weekly, depending on your treatment plan and your financial situation. Once an appointment is scheduled, we expect you to keep it. Our policy is to charge $_____ for missed sessions or for sessions cancelled within 24 hours of the scheduled appointment, except in case of emergency.

BILLING AND PAYMENTS

Payment for each session is due at the time it is held and it is always the patient's responsibility to know his or her insurance coverage and benefit details. If you have insurance that covers mental health and your therapist in your insurance network, GOC will make necessary arrangements to bill your insurance company for our services (after you sign a release giving us permission). Payment will likely

involve a co-payment or payment against your deductible, which your therapist will review with you. However, if your deductible or co-pay fee changes or differs, you are still responsible for paying the correct amount for any sessions conducted under that co-pay or fee. If you do not have insurance, or your therapist is not in your network, your fee for each session is $_____.
Your therapist may talk to you about charges for other professional services you may need (e.g., summary reports, extensive phone consultations). Charges for additional professional services are not usually covered by insurance.

Payments may be made in the form of cash or check. Although some therapists are also able to accept credit card payments, you must verify this with your therapist in advance. If a balance on your account (including no-show and cancellation fees) has not been paid for more than 60 days and arrangements for payment have not been agreed upon with your therapist and/or GOC, we have the option of using legal or other means to secure the payment. This may involve our contacting the person whom you have designated as having financial responsibility for your treatment, hiring a collection agency or going through small claims court. In most collection situations, the only information we will release regarding a patient is his/her name, the nature of services provided, and the amount due. We charge $10 charge for a returned check; thereafter, all payments must be in the form of cash.

CONTACTING YOUR THERAPIST

Our voicemail system is available to take your messages 24 hours/day. You may leave a non-urgent message for your therapist's voicemail at 215-947-8654 x_____, including messages related to appointments. The office staff does not keep therapist schedules and therefore does not coordinate therapist appointments. Your therapist will make every effort to return your call within 24 hours or less, with the exception of weekends and holidays.

In case of a clinical emergency, you may call our answering service at 877-340-4203 to leave a message for your therapist. If you cannot wait for the return call, please call 911 or go to the nearest emergency room.

CONFIDENTIALITY

In general, the privacy of all communications between a patient and a therapist is protected by law, and your therapist cannot share your private information with others outside of GOC without your written permission. There are a few important exceptions:

- A judge/court may order information from your therapist if they determine that the issues demand it.
- If your therapist believes that a child, elderly, or disabled person is being abused, they may be mandated to file a report with the appropriate state agency.
- If your therapist believes that a patient is threatening serious bodily harm to another, they may be mandated to take protective actions, including notifying the potential victim, contacting the police, or seeking hospitalization for the patient.
- If a patient threatens harm to self, the therapist may be obligated to seek hospitalization for the patient or to contact family members who can help provide protection.

ELECTRONIC MEDIA POLICY

Your therapist will advise you about their individual policy regarding communicating with you via email or text messages. **However, in the case of emergency, you should contact your therapist by phone, and not by email or texts**. The confidentiality of information you decide to share over email or text cannot be fully protected or guaranteed. If you choose to accept texts or emails from your therapist- although your therapist may take precautionary steps to protect your privacy- confidentiality cannot be guaranteed. GOC strongly discourages any public connection or communication on social media outlets between you and your therapist, even if your therapeutic relationship with GOC is not revealed.

We are happy to of service to you and your family. Please inform the Executive Director at ext. 269 if you have any questions or concerns that have remained unaddressed by your therapist.

Growth Opportunity Center

PATIENT READ AND KEEP

GROWTH OPPORTUNITY CENTER
215/947-8654
NOTICE OF PRIVACY PRACTICES

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

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 your treating clinician or the **Privacy Officer, Dr. Diane Sizer** at (215)947-8654 ext. 269.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Permissible Uses and Disclosures without Your Written Authorization We may use and disclose PHI without your written authorization, excluding Psychotherapy Notes, 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.

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.

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.

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.

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.

Uses and Disclosures Requiring Your Written Authorization

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.

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

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.

YOUR INDIVIDUAL RIGHTS REGARDING PHI

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.

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.

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.

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.

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.

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.

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. Diane Sizer** at (215)947-8654 ext. 269. 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 Executive Director.

EFFECTIVE DATE AND CHANGES TO THIS NOTICE

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

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.*

Growth Opportunity Center

PATIENT READ AND KEEP

PATIENT RIGHTS AND 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 the 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.

Statement of Members' Responsibilities

- 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.

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

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. Revised 9/3/2014,

I may change this notice at any time. I f 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). 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 J. KRAVITZ, Ed.D.
Licensed Psychologist
101 Greenwood Ave., Suite 410
Jenkintown, PA 19046
drk@dr-yjkravitz.com
215-635-3O11

Addendum to Privacy Notice
Effective 9/23/2013

If there is a breach of your confidentiality, then I must inform you as well as Health and Human Services. A breach means that information has been released without authorization or without legal authority unless I (the covered entity) can show that there was a low risk that the PHI has been compromised because the unauthorized person did not view the PHI or it was de-identified.

If you are self-pay, then you may restrict the information sent to insurance companies.

Most uses and disclosures of psychotherapy notes and of protected health information for marketing purposes and the sale of protected health information require an authorization. Other uses and disclosures not described in the notice will be made only with your written authorization. You must sign an authorization (release of information form) for releases unless it is for purposes already mentioned in this Privacy Notice (such as mandated reporting of child abuse, reporting of elder abuse, reporting of impaired drivers, etc.).

You have a right to receive a copy of your Protected Health Information in an electronic format or (through a written authorization) designate a third party who may receive such information.

YAACOV J. KRAVITZ, Ed.D.
Licensed Psychologist

101 Greenwood Ave., Suite 410
Jenkintown, PA 19046

drk@dr-yjkravitz.com
215-635-3O11

Secure Communication addition to Privacy Practices

Limits of Confidentiality

It is important for you to be aware of the risks, including but not limited to your confidentiality in treatment, of transmitting any protected health information by unsecured means. Electronic message

s can be intercepted in two ways. One is when the message is sent unencrypted; the message may be read by third parties who monitor internet traffic, such as server administrators. The second is when the message reaches the recipient but is viewed by someone else (e.g., if someone has access to the person's phone, computer, or other devices used to read or write messages). When a work email is used for communication, employers may have access to any messages that are sent.

Email or text should never be used to request assistance for emergencies. Electronic communication is never a substitute for face-to-face therapy; detailed or sensitive conversations should be reserved for in-person meetings. If you send any insecure communications, please be advised that I will respond only by phone or in person at our next scheduled session. While I will try to return secured/encrypted messages in a timely manner, I cannot guarantee an immediate response.

In order to insure that all of your communications with me are private, safe and secure I have established the following procedures for ALL communications. These procedures will take a few minutes for you to set up on your phone and computer, but will ensure that we are following all HIPAA requirements for the security of your information.

1. **Telephone and cell phone**. This is the most secure means of communication for voice calls as there is no data that is recorded so it can't be compromised. If you leave a message on my answering machine I am able to delete the message after it has been listened to. Any important information will be recorded in your record. Phones calls and encrypted texts are the best way to communicate information regarding scheduling and appointment times.

2. Text communication. If you wish to send me a text message from your cell phone **please do not use the basic SMS text app on your cell phone.**

Please go to https://whispersystems.org/ and install the "Signal Private Messenger" app. You can use this app to send totally secure encrypted texts. Signal is free and easy to set up. If you have any difficulty I will be happy to help you set it up. You will still be able to use your regular text app if you like for communicating with other people. You can also use Signal to send unencrypted texts to anyone who is not using Signal.

3. **E-mail**. E-mail is the least secure mode of communication. E-mail accounts may be hacked. Emails may remain on your (or my) e-mail provider's servers even after you have deleted them from your account. **I am requesting that you NEVER use regular e-mail for communication with me**.

As an **alternative** to regular e-mail I have established a Patient Portal which you may use to send secure communications to me, including uploading or downloading of any confidential documents. If you agree to use the Patient Portal I will send you a link from **Patient Ally** which you may use to set up a free account.

If in any event you wish to use regular email or text you must submit a written request using a "Request for non-Secure Communication" form that I can provide to you.