Richard Katz Psychology

phone: 224-392-3258 address: 9150 Crawford Avenue, suite 204, Skokie, IL 60076

Welcome

My goal is to provide you with the most effective and efficient treatment for you.

Your completing these forms *before* our first meeting will enable us to get started right away.

Please print and complete all the forms in this pdf. pack.

This pack contains the following documents:

- New teen client form, 1 page
- What's happening in my own words, 6 pages
- Parent's view points, 4 pages
- Contract for services, 2 pages
- Choice to use insurance, 2 pages
- Notice of Privacy Practices form, 2 pages
- Authorization to Release Information, 1 page

Thank you for your cooperation.

TEEN New Client Information Page

This form is required. You might need help from a parent, especially for the insurance information.
PLEASE PRINT LEGIBLY

Your Name____ ☐ Male ☐ Female
First Name Middle Last Name

Birth Date_______________School______________________________Grade_________
mm—dd—yyyy

Parent #1____
NAME ADDRESS

Parent #2____
NAME ADDRESS

If your parents live at different addresses, how many days/nights do you spend at Parent #1?________

Your Phone Number:________________________ Accept Texts? ☐ Yes ☐ No
Do I have permission to leave a message at this number? ☐ Yes ☐ No
Parent #1 Phone Number:____________________ Accept Texts? ☐ Yes ☐ No
Do I have permission to leave a message at this number? ☐ Yes ☐ No
Parent #2 Phone Number:____________________ Accept Texts? ☐ Yes ☐ No
Do I have permission to leave a message at this number? ☐ Yes ☐ No

Who is responsible for scheduling appointments?____________________________________

How will you get to and from appointments?_______________________________________

Insurance Information: PLEASE PRINT LEGIBLY

Member's Name____________________________Member's Employer__________________

Insurance Company Name_____________________Plan Name________________________

Member ID #________________________________Group #___________________________

Your relationship to the member: ☐ Child / Dependent ☐ Self

Member's Birth Date____/____/______ First Appointment Date____/____/______
mm dd yyyy mm dd yyyy
Today's Date ____/____/______
mm dd yyyy
Emergency Contact: Name, Phone, Relationship:_______________________________________

How did you hear about Richard Katz, Psy.D.?

FEES AND COPAYS ARE DUE AT THE BEGINNING OF THE SESSION, cash, check, or credit card.

WHAT'S HAPPENING, IN MY OWN WORDS...

My legal name_______________________________________**My nickname**_______________________

My birthday____________________**Where I go to school**________________________**Grade**________
mm—dd—yyyy

This is What I'm doing too much of, or too often, or at the wrong time that gets me in trouble.
List everything you can think of, and what happens afterwards, or the consequences.

This is What I'm not doing, or not enough, or not doing what's "expected" of me that gets me in trouble. List everything you can think of, and what happens afterwards, or the consequences.

What I do when I want to get on my parent's good side, or my teacher's good side.

How often do you do these things?

What concerns do you have about yourself or your family?

My Name___________________________________

Goals: Based on what you wrote on page 1, what do you want to work on first? How will you know when you are successful?

Think about the people who you think help you.
These people might be your parents, brothers and sisters, aunts and uncles, cousins, friends, teachers, coaches, people at church or synagogue, or anyone else.

Please write down the names of people who you think help you,
Tell me HOW they help you.

____

____

____

____

____

Who's in my family.

Parent Name	**Biological?**	**Legal?**	**Has Custody**	**Nights per week**	**Days per week**
	Yes No	Yes No	Yes No		
	Yes No	Yes No	Yes No		
	Yes No	Yes No	Yes No		
	Yes No	Yes No	Yes No		

Sibling Name	**Age**	**Biological?**	**Lives with Teen**	**Explanations**

Significant People NOT Living with your Teen	**Age**	**Relationship**	**Grade or Job**	**Role in Teen's Life**

My Name_____________________

Past Psychotherapy: Describe any past therapy that you, your parents, or other family members have had. If you need more room, use the back of the page.

What WAS HELPFUL, or WHAT DID YOU LIKE about each therapist and counseling?
What WAS NOT HELPFUL, or what did you NOT like about each therapist and counseling?

____

____

____

Drugs, Alcohol, Tobacco: Does anyone in your family currently use any substance? Has anyone **ever** used any substance? If yes, please describe it. Use the back of the page if you need the space.

CONCERN CHECK LIST Please make a check in the space ( ) for those that apply to you

Home

1. I feel part of my family	Seldom	Just a little	Pretty Much	Very Much
2. I am physically healthy	Seldom	Just a little	Pretty Much	Very Much
3. I feel accepted by everyone at home	Seldom	Just a little	Pretty Much	Very Much
4. I get along with my parents	Seldom	Just a little	Pretty Much	Very Much
5. I participate in decision making	Seldom	Just a little	Pretty Much	Very Much

School

1. I get to school on time	Seldom	Just a little	Pretty Much	Very Much
2. I get along with kids at school.	Seldom	Just a little	Pretty Much	Very Much
3. I am respected by kids at school.	Seldom	Just a little	Pretty Much	Very Much
4. I am respected by my teachers	Seldom	Just a little	Pretty Much	Very Much
5. I enjoy school	Seldom	Just a little	Pretty Much	Very Much
6. I am a hard worker	Seldom	Just a little	Pretty Much	Very Much
8. I balance school and play	Seldom	Just a little	Pretty Much	Very Much

Emotional

1. I cope well with frustration	Seldom	Just a little	Pretty Much	Very Much
2. I cope well with disappointment	Seldom	Just a little	Pretty Much	Very Much
3. When I'm mad everyone knows it	Seldom	Just a little	Pretty Much	Very Much
4. I am happy with life	Seldom	Just a little	Pretty Much	Very Much
5. I accept responsibilities for my mistakes	Seldom	Just a little	Pretty Much	Very Much
6. I can take constructive criticism	Seldom	Just a little	Pretty Much	Very Much
7. I think before I act	Seldom	Just a little	Pretty Much	Very Much
9. I have good self-esteem	Seldom	Just a little	Pretty Much	Very Much

My Name____

Social

1. I make and keep friends	Seldom	Just a little	Pretty Much	Very Much
2. I'm open to new ideas	Seldom	Just a little	Pretty Much	Very Much
3. I am considerate of others	Seldom	Just a little	Pretty Much	Very Much
4. I stand up for myself	Seldom	Just a little	Pretty Much	Very Much
5. I show leadership	Seldom	Just a little	Pretty Much	Very Much
6. I am able to compromise	Seldom	Just a little	Pretty Much	Very Much
7. I'm comfortable around others	Seldom	Just a little	Pretty Much	Very Much
8. I get along with others	Seldom	Just a little	Pretty Much	Very Much

Attention

1. I can work when there are distractions	Seldom	Just a little	Pretty Much	Very Much
2. I maintain attention to tasks	Seldom	Just a little	Pretty Much	Very Much
3. I follow through on tasks	Seldom	Just a little	Pretty Much	Very Much
4. I am able to compromise	Seldom	Just a little	Pretty Much	Very Much

Problems That You Are Struggling With

( ) Depression
( ) Anxiety or panic attacks
( ) Suicidal actions
( ) Brother/sister problem
( ) Violence in family- actual or threatened
( ) Sexual problem
( ) Low self – esteem
( ) Legal problems
( ) Major losses/difficult changes
( ) Communication problems
( ) Conflict with parents
( ) Suicidal thoughts
( ) Remarried family problems
( ) Anger/temper problems
( ) School problem
( ) Sexual Abuse
( ) Job problems.
( ) Eating problems
( ) Death of a loved one

Education History

Have you ever repeated a grade? ☐ YES ☐ NO If you have, what grade was that?________________

Have you ever skipped a grade or been double promoted? ☐ YES ☐ NO If so, what grade?__________

Have you ever received Special Education services or been given an IEP/504 Plan? ☐ YES ☐ NO

If yes, when was that____

Circle any of the following problems that you have had at school OR at home.

Fighting	Lack of Friends	Drug/Alcohol Use	Detentions
Suspensions	Learning Disabilities	Poor Attendance	Poor Grades
Gang Influences	Incomplete Homework		Behavior Problems

My Name______________________________________

Medical History:

What is the name of your doctor?____

When was your last medical examination?____________________
mm—dd—yyyy

Do you know if your mom had any problems when she pregnant with you or when she delivered you? If yes, please describe them here.

Circle any of these medical problems you have or had.

Serious Accident	Hospitalization	Surgery	Head Injury	High Fever
Seizure/ Convulsion	Loss of Consciousness		Eye or Ear Problem	Allergies
Asthma	Meningitis		IBS/Crohns Disease	Cutting/ Self Injury

Other:_____________________________

Do you smoke cigarettes, vape, or chew tobacco? ☐ YES ☐ NO
Do you drink alcohol or use substance for fun or to get high? ☐ YES ☐ NO

Please list any medical problems or physical handicaps:

If you are currently taking any prescription medications, please list them here.

Are you taking any prescription medications? ☐ YES ☐ NO

Other History:

Do you think you were ever physically, verbally, or sexually abused? ☐ YES ☐ NO.
If YES, please describe.

My Name______________________________

Have you ever thought of hurting yourself or someone else? ☐ YES ☐ NO

Have you ever purposely hurt yourself or someone else? ☐ YES ☐ NO
If you answered YES to either question, please describe the situation here.

Have you ever had a serious emotional loss, like someone dying or someone very special to you leaving you? ☐ YES ☐ NO. If you answered yes, please describe.

What is currently stressful to you and / or your family?

How well are you coping or getting along?

Please place an “X” on the numbered scale below to show how well you are coping at the present time. 100% means that you are coping the best that you can at this time, while 0% means that you are not coping at all.

0%-----10%-----20%-----30%-----40%-----50%-----60%-----70%-----80%-----90%-----100%

How Many Sessions Do You Think You Will Need To Get What You Want?

FROM THE PARENT'S PERSPECTIVE....

Please complete this form to your best ability. Your information will help us (you, your teen, and me) clarify the situation and provide clues to finding the best answers for you.

Teen's Legal Name________________________________Nick Name___________________________

Birth Date____________________School__________________________Grade__________________
mm—dd—yyyy

Too Much Of:
Please list and describe what your teen is doing too much of, or too often, or at the wrong times that gets him or her in trouble. LIST EVERYTHING!

Not Enough Of:
Please list and describe what your teen is doing too little of, or not often enough, or at the wrong times that gets him or her in trouble. LIST EVERYING.

Great Stuff:
He or she isn't *all* bad! What does your teen you do that you appreciate? What does he or she do that others like and appreciate? LIST EVERYTHING.

Other Issues:
What other concerns might you have about your teen, your family, or yourself?

Teen's Name___________________________________

Treatment Goals:
When you look at your answers to the preceding questions about what your teen is doing too much of, not enough, what he or she is good at, and your other concerns, what problem or issue to do you want to first work on? How will you know when that goal has been achieved?

Who's in Your Family?

Parent Name	Biological?	Legal?	Has Custody	Nights per week	Days per week
	Yes No	Yes No	Yes No		
	Yes No	Yes No	Yes No		
	Yes No	Yes No	Yes No		
	Yes No	Yes No	Yes No		

Sibling Name	Age	Biological?	Lives with Teen	Explanations

Significant People NOT Living with your Teen	Age	Relationship	Grade or Job	Role in Teen's Life

Past Psychotherapy: Describe any past therapy that you, your teen, or other family members have had. If you need more room, use the back of the page.

Teen's Name___________________________________

Drugs, Alcohol, Tobacco; Does anyone in the teen's family currently use any substance? Has anyone **ever** used any substance? Describe current and past usage.

Education History:

What school does your teen attend?____________________________Grade______________________

Address:____

Phone:___________________ Counselor's Name____

Do you regularly contact the school? ☐ YES ☐ NO.
What issues do you discuss when you do contact the school?

Has your teen ever repeated a grade? ☐ YES ☐ NO. Which grades?________________________
Has your teen ever recieved Special Education Services, or given an EIP/504 Plan? ☐ YES ☐ NO
Summarize that plan here:

Specific Issues: Has your teen ever had any of the following at HOME or at SCHOOL?
Circle the ones that apply.

Fighting	Lack of Friends	Drug/Alcohol Use	Detentions
Suspensions	Learning Disabilities	Poor Attendance	Poor Grades
Gang Influences	Incomplete Homework	Behavior Problems	

Medical History:
Teen's Physician:____________________________________Phone______________________________

Address:____
Last Medical Exam:_____________________
mm—dd—yyyy

Teen's Name__________________________________

Did the child's mother use tobacco, alcohol, drugs, or medications during pregnancy? ☐ YES ☐ NO
List substances and medications used during pregnancy here:

Did the child's mother have any problems during pregnancy or delivery? ☐ YES ☐ NO
Describe those problems here:

Circle any of the following that your teen has had:

Serious Accident Hospitalization Surgery Head Injury High Fever

Seizure/ Convulsion Loss of Consciousness Eye or Ear Problem Allergies

Asthma Meningitis IBS/Crohns Disease Cutting/ Self Injury

Other:______________________________

Sexually Active: Is Your Teen Sexually Active? ☐ YES ☐ NO

Substance Use: Does your teen use alcohol, tobacco, or drugs? ☐ YES ☐ NO

What are your feelings about this?____

Medications: Please list all of the medications, vitamins, herbal supplements, etc. that your teen takes.

Psychiatrist: If your teen is seeing a psychiatrist, complete a release of information form.

Abuses: Has your teen ever been verbally, physically, or sexually abused? ☐ YES ☐ NO.
Please describe

Aggression: Has your teen ever *spoken* about hurting him or herself or someone else? ☐ YES ☐NO
Has your teen ever purposely hurt him or herself or someone else? ☐ YES ☐ NO
Please describe

Losses: Has your teen experienced any serious emotional losses (death or physical separation from a parent or significant person)? ☐ YES ☐ NO. Please describe.

Current Stresses: Use the back of this sheet to explain current stresses for you and your family.

Contract for Services and Financial Agreement **Page 1 of 2**

Richard Katz Psychology
9150 Crawford Ave, ste 204, Skokie IL 60076
224-392-3258

Richard Katz Psychology provides psychotherapy and behavioral health services. Richard Katz, Psy.D. is licensed clinical psychologist in the State of Illinois. Your contract is with Richard Katz Psychology, LLC.

Client Rights and Risks: You have a right to inspect your records. Psychotherapy requires that you discuss what is troubling you and be willing to change your thoughts, beliefs, and behavior. Psychotherapy may cause you to remember unpleasant events, arouse intense emotions, and change close relationships. The purpose of psychotherapy is resolve your issues.

Confidentiality: Your information is held in confidence and will not be released without your consent.
Exceptions:

- I am required by law to report suspected child or elder abuse or neglect, inability to care for one's basic need for food, clothing and shelter, and threatening harm to oneself or others
- The courts may subpoena my records
- Information regarding diagnosis and treatment will be provided to insurance companies ONLY if you choose to use your insurance company to pay for services.

Appointments: All sessions are by appointment only. Standard appointment time is 53 minutes. Late arrivals will reduce the time available. **Cancellations less than 24 hours ahead of time and "no shows" will be billed to your credit card for the missed appointment amount.**

Fees:

Payment and copays for service are required at time of service.
Health insurance may help recover some of the costs. You must verify the amounts that insurance will pay. **If your policy requires preauthorization, YOU must obtain it before your first visit. Without preauthorization approval, your credit card will be charged the full amount.**
The actual fee your insurance company pays is a negotiated fee NOT my standard fee.
If you have not yet met your deductible**, you will pay your insurance company's negotiated fee, not my standard fee.**

Self Pay Clients: All fees must be paid in full at the time of service. You will be provided with a receipt upon request. Speak with me about reduced fees.
Clients Using Insurance: Copay must be paid in full at time of service. Your insurance will be billed for the full service cost. I do not negotiate settlements or disputed costs.
All Clients: Clients and parents/guardians of minor clients are responsible for payment and insurance claims. Accounts become delinquent after thirty (30) days. **Delinquent accounts may be sent to a collection agency. You are responsible for collection agency fees.**

Phone Calls: Phone calls over five (5) minutes are billed in 15 minute units at $40 per 15 minutes. This will be charged to your credit card.

Client/Responsible Party Acknowledgementa nd Acceptance of Terms: I have read and understand both pages of this Contract and Financial Agreement, and I have been given a copy of the Contract and Financial Agreement. I hereby authorize Richard Katz Psychology, LLC to abide by my completed **Insurance Declaration Form** which I submitted with this contract. I understand that my insurance coverage is between me and my insurance company. I agree to accept financial responsiblity for payment of all charges. I agree to pay for collection and/or court costs and reasonable legal fees if I do not pay the bill. I understand that co-pays and deductibles are not negotiable.

Consent to Treatment and Fee: I agree to full responsibility for all expenses incurred by me and/or on account of this client and assign Richard Katz Psychology and all insurance benefits due me to the full extent of my financial obligation to Richard Katz Psychology. I have received a copy of Richard Katz Psychology Privacy Policy. I have submitted a completed the Insurance Declaration Form to Richard Katz Psychology.

Contract for Services and Financial Agreement **Page 2 of 2**

Fee Schedule
I understand that the STANDARD FEES detailed in the table below may be submitted to my insurance company for payment ONLY if I authorize Richard Katz Psychology to submit a bill to my insurance company. I understand that I am ONLY responsible for co-pays and deductible amounts.

I understand that ADDITIONAL FEES detailed in the table below are totally my responsiblity. These fees will not be submitted to my insurance company.

Self Pay Clients: Speak with me to determine your eligibilty for reduced fees.

STANDARD FEES	0-30 minutes	31-52 minutes	53-60 minutes	Flat Fees	
Intake Interview				$210	
Individual Psychotherapy Session	$100	$165	$200		
Multiple Family Members/Clients Per Person Fee	$25	$25	$25		
Consultation w/Family-client not present				$165	
ADDITIONAL FEES – paid by you	5-60 minutes				Additional 30 minutes
Psychotherapy After the First 60 minutes	---				$75
Consultation with outside agencies/schools	$165				$75
Cancelled within 24 hours or missed	--			$125	
Depositions, subpoenas,legal or court proceedings	$300				$150

Client(s) Signature(s)____Date_______________________
mm-dd-yyyy

Client(s) Signature(s)____Date_______________________
mm-dd-yyyy

If I fail to attend a scheduled appointment or cancel a scheduled appointment within 24 hours, I authorize Richard Katz Psychology LLC ot charge my credit card with a fee of $125.

Credit Card Type: Visa ☐ MC ☐ AMEX ☐ DISC ☐ Security Code_______ Exp. Date: ____/______

☐☐☐☐ -- ☐☐☐ ☐ -- ☐☐☐☐ -- ☐☐☐☐

Billing Address of Credit Card

Street City/State Zip Code

Name as it appears on card Signature Date

____________________@________________________
Email Address

Signature

YOU MUST COMPLETE THIS FORM BEFORE SERVICES WILL BE DELIVERED

KNOW YOUR OUT OF POCKET EXPENSES BEFORE RECEIVING SERVICES

By choosing to pay for services yourself, I (Richard Katz Psychology) will not be authorized to share your records with your insurance company.

By choosing to submit your bills to your insurance company, I (Richard Katz Psychology) will share your records with your insurance company.

☐ OPTION ONE. I want to pay for services myself. I will pay for sessions "out-of-pocket" by cash, credit card, or check. I do not authorize Richard Katz Psychology to share my private information with my insurance company

☐ OPTION TWO. I want my insurance company to pay for services. If Richard Katz Psychology is and "in network" p;rovider my rates may be discounted according to the contract Richard Katz Psycholgy has with my insurance company. I might still have to pay a co-pay. Unless my deductible has been met, I will have to pay full fee until my deductible is met.

If Richard Katz Psychology is NOT "in network" I will be responsible for copays, coinsurance amounts, deductible payments, and any fees not covered by my plan. I will pay full fee to Richard Katz Psychology and will submit receipt for services to my insurance company for my reimbursement.

By choosing OPTION TWO, you MUST complete page 2 of this document.

____ ______________________

Client or Client's Representative's Signature Date mm—dd—yyyy

____ ______________________

Richard Katz, Psy.D. Date mm—dd—yyyy

VERIFYING COVERAGE BENEFITS DOES NOT GUARANTEE THAT THE INSURANCE WILL PAY

- HOW TO DETERMINE YOUR INSURANCE COVERAGE,
- HOW TO DETERMINE WHAT YOUR COPAY WILL BE
- HOW TO DETERMINE IF YOU WILL NEED TO PAY MORE THAN YOUR COPAY.

YOU MUST CALL YOUR INSURANCE COMPANY.
HAVE THE FOLLOWING INFORMATION BEFORE YOU CALL

Insured's Name________________________Birth Date____/____/____

Policy ID #____________________________Group #______________

Client's Name__________________________Birth Date____/_____/_____

Insurance Company Name	Phone:	Mail Claims To:

Date and Time of Call____________________________Name of Person You Spoke To______________

What to Say...

"I'm calling to clarify my benefits and coverage for out-patient mental health."

"Is Richard Katz, Psy.D. on your participating provider list?
His NPI is 134 621 6504"

☐ YES (In Network)
☐ NO (Out of Network)

If Richard Katz is IN NETWORK, ask for network benefits.
If Richard Katz is NOT IN NETWORK, ask for OUT of NETWORK benefits.

"What is my deductible amount? $___________. How much has been met to date? $____________"

"Is that for my family or for the individual?____________ Is it per Calendar Year? ☐ Yes ☐ No"

"When does the calendar year begin______________"

"What is my copay? $_____________ "Is that a fixed amount or a percentage?___________________"

"What is the Effective Date of my policy?___________________

"How many visits am I allowed per calendar year?_______________

"What is the lifetime maximum?_______________ Is Pre-authorization required? ☐ Yes ☐ No

"What phone number must my therapist call to get pre-authorization? ___________________________

RICHARD KATZ MUST CALL TO GET PRE-AUTHORIZATION IF NEEDED BEFORE SESSION.

NOTICE OF PRIVACY PRACTICES FOR RICHARD KATZ, Psy.D.

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU
- *MAY BE USED AND DISCLOSED*
- *HOW YOU CAN GET ACCESS TO THIS INFORMATION*

1. USE AND DISCLOSURE OF PROTECTED HEALTH CARE INFORMATION—WITH YOUR CONSENT

I may need to give insurance companies or other agencies (such as Medicare) the minimum necessary information in order for them to pay me for the services I have provided to you.
This is explained in "The Choice to Use Insurance" Form and "Contract for Service and Financial Agreement" Form.

2. INFORMATION DISCLOSED—WITHOUT YOUR CONSENT

a. EMERGENCIES: Information may be shared in the event of an immediate emergency you are facing—for example if you suffer a medical emergency in my office and paramedics are called.
b. JUDICIAL PROCEEDINGS: Information may be shared if I am presented with a valid court order or other lawful process.
c. PUBLIC HEALTH ACTIVITY: If I judge that you are in immediate danger to yourself or others, I may disclose health information about you to legal authorities, as well as alerting any other person who may be in danger.
d. CHILD / ELDER ABUSE: I am a mandated reporter which may require me to disclose health information about you if there is the suspicion of child and/or elder abuse or neglect
e. CRIMINAL ACTIVITY OR DANGER TO OTHERS: I may disclose health information if a crime is committed on my premises or against me or others or if I believe there is someone in immediate danger.
f. NATIONAL SECURITY, INTELLIGENCE ACTIVITIES, PROTECTIVE SERVICE TO THE PRESIDENT and OTHERS. I may release health information about you to federal officials authorized by law in order to protect national or international persons or in case of national security
g. HEALTH OVERSIGHT ACTIVITIES: I may disclose health information to a health oversight agency for activities authorized by law, such as audits or inspections of records by the government to assure compliance with civil rights laws. This type of inquiry is typically anonymous.
h. MARKETING: I may send you announcements or newsletters about services I provide that I think might be of interest to you. You may request that your name be removed from this notification list. At no time will I share your name with any other third party.
i. SCHEDULING APPOINTMENTS: I may use your phone number to call or text you or leave messages regarding your appointments.

3. YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

a. RIGHT TO INSPECT AND COPY: You have the right to look at and get copies of your health information, with limited exceptions. Your request must be in writing. A reasonable charge may be made for this service operation.
b. RIGHT TO AMEND: You have the right to request that I amend your health information. Your request must be in writing. You must explain why the information should be amended. I have the right to deny that request under certain circumstances.

c. RIGHT TO AN ACCOUNTING OF DISCLOSURES: You have a right to receive a list of instances where I disclosed your health information for a purpose other than treatment or payment or health care operations. You must submit your request in writing. This accounting will be available for 7 years after the last date of service with Richard Katz, Psy.D.
d. RIGHT TO REQUEST RESTRICTIONS: You have the right to request a limitation or restriction of the health information I use or disclose about you. For example, you could ask me to not share information with your insurance company, in which case you would be totally responsible for service fees. To request a restriction, you must make your request in writing. This request does not apply to section 2, INFORMATION DISCLOSED WITHOUT YOUR CONSENT.
e. RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS. You have the right to request that I communicate with you in a certain manner or location. For example, you may request that I communicate with you only via a specified phone number. You must make this request in writing.
f. RIGHT TO OBTAIN A PAPER COPY OF THIS NOTICE: You have the right to receive a paper copy of this notice. Copies are available at my office and online at www.RichardKatzPsychology.com.
g. REVOCATION OF WRITTEN AUTHORIZATION FOR RELEASE OF INFORMATION. You may revoke a written authorization for release of information at any time. The revocation must be in writing, and dated. The revocation will become effective when it is recieved in my office. The revocation will only be for disclosures not already completed.

I may change these privacy practices at any time provided they are permitted by applicable laws.

QUESTIONS AND COMPLAINTS

You may file a complaint with me if you believe your privacy rights have been violated. You may also file a complaint with the U.S. Department of Health and Human Services. There is no penalty for filing a complaint.

For more information about HIPAA (Health Insurance Portability and Accounting Act of 1996)

Write to: U.S. Department of Health and Human Services
Office of Civil Rights
200 Independence Avenue S.W.
Washington, D.C. 20201
Telephone: 212-619-1257

____ ____/_____/_____

Client / Responsible Party Signature Printed Name Date

____ ____/_____/_____

Richard Katz, Psy.D. Date

AUTHORIZATION FOR RELEASE OF INFORMATION

Purpose of Disclosure: This information will assist understanding and planning of my treatment

Client's Name____Birth Date_____/_______/_______
PRINT YOUR NAME LEGIBLY mm dd yyyy
If client is a minor, the minor's parent or authorized person

Name:____Relationship to Client_________________
PRINT YOUR NAME LEGIBLY

I authorize Richard Katz, Psy.D. to share and recieve confidential record information with and from...

Name	Phone and Email	Address

Information shall consist of Duplicate Records and/or verbal consultation regarding treatment or education limited to the check marked boxes below

- ☐ **All clinical records**
- ☐ Social History
- ☐ Psychological Evaluation
- ☐ Medical History
- ☐ Educational Evaluation
- ☐ Psychiatric Evaluation
- ☐ Mental Health Information
- ☐ Discharge Summary
- ☐ Master Treatment Plan
- ☐ PCP Contract Form
- ☐ Drug / Alcohol tests and results diagnosis, treatment info
- ☐ Other_____________________

Legal Stuff:

1. This authorization may be revoked at any time.
2. Revoking this authorization, however, will not cancel any prior action that has occurred.
3. The authorization is valid for one year after the last day of your clinical treatment.
4. A photocopy, fascimile, or duplicat copy of this authorization is as valid as the original.
5. The person signing this has right to receive a copy of this document. BUT you must initial here__
6. I release Richard Katz, Psy.D. from any liability that may arise from this action whether or not forseen at present.
7. Certain medical records, including drug and alcohol abuse information may be protected by Federal Regulations. (Drug Abuse and Treatment Act of 1972, 21 USC 1175; Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970, 42 USC 4582)

____ ____
Signature of Client or Legal Representative Date Witness Date

☐ I do not give Richard Katz, Psy.D permission to contact anyone beyond his legal responsibility as a mandated reporter in the State of Illinois

____ ____
Signature of Client or Legal Representative Date Witness Date