Dr. Jessica M. Gurvit, PSY. D., P.A. & Associates
Psychology & Wellness Center

PATIENT INFORMATION DATE: _____

Name: _____
First Initial Last

Birth date: _____ Age: _____ Sex: _____

Address:(NO PO Box) _____ Apt # _____

_____
City State Zip Code

Home Telephone #: (____) _____ Work Telephone #: (____) _____ Ext: _____

Cellular # (____) _____ Email: _____
(Please place a check next to the best phone number to reach you.)

Who referred you to our office? _____

Name of Primary Care Physician: _____ Telephone: _____

Patient Social Security Number: _____ Your place of employment: _____

Your position or title: _____ How long have you worked there? _____

INSURANCE INFORMATION

INSURANCE COMPANY NAME: _____TELEPHONE NUMBER: _____

POLICY OR ID # _____ GROUP OR PLAN # _____

SUBSCRIBER NAME: _____BIRTH DATE: _____

Address: (If different from patient) _____ APT_____

_____
City State Zip Code

Home Telephone #: (____) _____ Work Telephone #: (____) _____ Ext: _____

Cellular # _____ Email: _____
(Please place a check next to the best phone number to reach you.)

Social Security Number: _____ Place of employment: _____

Other insurance coverage? _____ Name: _____

Subscriber: _____ ID: _____

Please turn to the next page.

RELATIONSHIPS **IF PATIENT IS A MINOR CHILD, FILL OUT FORM ON PAGE 4***

Single? How Long? _____

☐ Married ☐ Live Together ☐ Involved and live apart? How Long? _____

Your Partner's Name: _____

Your Partner's Place of Employment: _____

Your Partner's Occupation: _____

Telephone Number: (____) _____ Ext: _____

☐ Separated ☐ Divorced ☐ Death of Partner? How long apart? _____ Together? _____

Name of prior significant relationships: Year began? Year ended?

_____

_____

When was the last time you remember feeling emotionally well? _____

EDUCATION

Your Education: ☐ Grade School ☐ High School

☐ College ☐ Graduate Study

If College, your major: _____

RELIGION

Yours: _____ Active ☐ Inactive ☐

Partner's: _____ Active ☐ Inactive ☐

FAMILY MEMBERS

Identify all persons who are your children, for whom you assume personal or family responsibility, or persons who live with you.

	Name	Relationship	Age
☐			
☐			
☐			

Place a check next to those who live with you.

HEALTH CARE INFORMATION

Current Health Problems:

_____

Current Medications:

_____

Are you seeing any other Physician(s) for Treatment?_____If yes, print name(s) & telephone number(s)

Physician Name:_____Telephone:_____

Previous psychological, psychiatric, chemical dependency assistance:?

	Therapist	Reason	Year Began	Year ended
You:				
Partner:				

Previous psychiatric or medical hospitalizations:

_____

Ever thought/been told you may have a drinking or drug problem? ☐

Ever thought/been told you may have a problem with food/eating? ☐

Have you ever really considered or attempted suicide/homicide? ☐

In case of emergency call: _____

Home telephone #: _____ Cell Telephone #: _____

_____ _____

Client's Signature Date

If you're here with your spouse or partner, please have them fill out their own copy of this form (independently).

After completing entire form, click the "Submit" button on the bottom of page 10 or 11, or send to jgurvit@bellsouth.net

Additional space to answer any questions is available on Page 11 of this form.

CHILD INFORMATION FORM

Please provide the following information about your child. This information will help me understand the nature of your concerns and how I may be able to help you. **Please be as complete as possible.**

Child's Name: _____

Date of Birth: _____ **Age:** _____

Name of Person Completing Form: _____

Relationship to Child: _____

Home Address: _____ **Zip Code:** _____

Home Phone: (____) _____ **Work Phone:** (____) _____

Pager: (____) _____ **Cellular Phone:** (____) _____

Name of Child's Current School: _____

Grade: _____ **How Long Attended:** _____

Prior School History (Names & Dates) _____

_____

Who Referred You? _____

Please list any family members (whether living at home or away), along with other people who are living in your home.

NAME	AGE	RELATIONSHIP	OCCUPATION / SCHOOL

_____

_____

Brief Medical History & Current Medications _____

_____

_____

CONSENT TO USE AND/OR DISCLOSE PROTECTED HEALTH INFORMATION FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

As a condition of providing treatment to you, **Dr. Jessica M. Gurvit, P.A. & Associates** requires your consent to use and disclose protected health information about you to carry out treatment, payment, and health care operations.

You may revoke this consent at any time by notifying
Dr. Jessica M. Gurvit, P.A. & Associates *in writing*, except to the extent that the provider has taken action and reliance on your consent.

Please refer to the Notice of Privacy Practices for Protected Health Information ("Privacy Notice") for a more complete description of the uses and disclosures that
Dr. Jessica M. Gurvit, P.A. & Associates may use of your protected health information. You have the right to review the Privacy Notice prior to signing this consent.

Dr. Jessica M. Gurvit, P.A. & Associates has reserved the right to change its privacy practices described in this Privacy Notice. In accordance with law, the terms of the Privacy Notice may change. At any time, you may obtain a copy of the current Privacy Notice and any revised notice.

You have the right to request that **Dr. Jessica M. Gurvit, P.A. & Associates** restrict the manner in which your protected health information is used or disclosed to carry out treatment, payment, or health care operations. **Dr. Jessica M. Gurvit, P.A. & Associates** is not required, however, to agree to such requested restrictions. If, however
Dr. Jessica M. Gurvit, P.A. & Associates agrees to the requested restriction,
Dr. Jessica M. Gurvit, P.A. & Associates will honor the request and it will be binding.

I hereby consent to the use and disclosure by **Dr. Jessica M. Gurvit, P.A. & Associates,** its workforce, and its business associates of my protected health information for purposes of treatment, payment, and health care operations.

Signature: _____

Signature of Personal Representative of Patient: _____

Description of Representative's Authority to Act on behalf of Patient: _____

Date: _____

CONSENT TO TREAT MINOR CHILD

As the parent/legal guardian of _____

Name of Child

I hereby give consent to Dr. Jessica M. Gurvit, Psy. D. P.A. & Associates, Inc. to provide the therapeutically necessary treatment to my child named above.

_____

Name of Patient

_____ _____

Signature of Parent/Legal Guardian **Date**

AUTHORIZATION WHEN HEALTH CARE PROVIDER REQUESTS USE OR DISCLOSURE FOR ITS OWN USE OF PROTECTED HEALTH INFORMATION

I hereby authorize Dr. Jessica M. Gurvit, P.A. & Associates, Inc. to use and disclose my information to:

Name: _____Telephone: _____

Name: _____Telephone: _____

for the following identified purposes:

_____

_____

I may revoke this consent at any time by notifying the AFCH provider *in writing*, except to the extent that the provider has taken action and reliance on this consent.

Once the uses and disclosures have been made pursuant to this authorization, they may be subject to re-disclosure by any recipient and no longer protected by federal privacy laws.

Dr. Jessica M. Gurvit, P.A. & Associates, Inc. will not condition treatment or payment on my providing authorization for this use or disclosure except to the extent provision of health care is solely for the purpose of creating protected health information for disclosure to a third party on provision of an authorization for disclosure of the protected health information to such third party.

I understand that I may inspect or copy the protected health information to be used or disclosed under this authorization. I understand I may refuse to sign the authorization. I understand that if use or disclosure of the requested information will result in the direct or indirect remuneration to the provider from a third party, a statement referencing such remuneration will exist in this authorization.

I understand that I may receive a copy of this authorization, upon request.

Signature:_____Date:_____

Signature of Personal Representative of Patient:_____

Description of Representative's Authority to Act on behalf of Patient:_____

MEMO OF UNDERSTANDING

Confidentiality and privileged communication are rights of all clients of psychologists and counselors according to the law and professional ethics. No information about you, or the psychological or counseling services provided to you, will be released without your permission. There are, however, certain circumstances in which it may be required or helpful to release patient information:

1) If a court of law issues you a legitimate subpoena, then we are required to provide the information specifically described in the subpoena. 2) If you indicate that you intend to hurt or kill yourself or someone else, then we must act to notify potential helpers or victims if we believe there is a real danger. 3) If you report or we suspect that you are a perpetrator or victim of child abuse or molestation, then we are obligated to report this to the authorities if it is or could be a problem. 4) If you are in psychotherapy and/or being evaluated by order of a court of law, the results of the evaluation and/or treatment may be revealed to your probation officer or the court. 5) If you are referred by or to a professional, such as a physician or an Employee Assistance Program, then we may discuss your progress and exchange information that may be helpful to your overall treatment. 6) If you have had previous psychotherapy or are referred to another psychotherapist, we may contact your form or future therapists and exchange information that may be helpful to your overall treatment. 7) If you insurance or managed care company requires us to provide them with patient information, we may release that information to them to determine coverage or reimbursement. 8) If billing is done by a company contracted by Dr. Jessica M. Gurvit, we may release that information to them to determine coverage and receive reimbursement. 9) If you are a minor, your parents or guardians must be informed of your progress, if they ask, but we do not have to tell them details. You have read the above and understand the therapist's social, legal, professional and ethical responsibilities to make such decisions as necessary.

You understand that you must let my staff or answering service know that it is an emergency if you need to speak with your therapist on an emergency basis. Also, you agree to let your therapist know if you are feeling suicidal or homicidal, so appropriate arrangements can be made.

Patient Signature (Parent is if patient is minor child)	**Date**
Jessica M. Gurvit, Psy. D., P.A.	
Jessica M. Gurvit, Psy. D., P.A.	**Date**

PATIENT AGREEMENT

Release of information:

I hereby give consent for you to report back to the Physician who referred me. This report is only for the purpose of informing that I have followed through on treatment and to occasionally advise of progress, but does not cover the release of information that I may disclose within my treatment sessions.

Cancellation:

I hereby authorize treatment by Jessica M. Gurvit, Psy.D., P.A. & Associates I understand that I am required to provide **at least 36 business hours** (Monday appointments require notice not later than Friday, 12:30 p.m. to correspond with the Monday appointment) advance notice if I am unable to keep the scheduled appointment. Unless this notice of cancellation is provided, I will be charged for the reserved appointment at the full session rate. If I am late for my appointment, I understand that my session cannot be extended beyond its regular time.

Financial:

I am responsible for providing signed insurance claim forms and all necessary information for filing the claim for benefits if acceptance of assignment of insurance benefits has been made. I assume financial responsibility for all charges that may be incurred for treatment rendered to me and/or my family. Should a session be denied by insurance for any reason, I will be fully responsible for payment. If insurance does not pay in a timely fashion, I agree to assist in collection efforts. If I receive a check from insurance in error, I will endorse and forward the check to the offices of Jessica M. Gurvit, Psy.D., P.A.. In general, all insurance payments received are for payment of sessions. I understand that unless I have FULLY PAID for co-payment and the amount expected from insurance, any checks received by me are due to Dr. Jessica M. Gurvit, Psy.D., P.A. & Associates. I understand that I am responsible for paying my co-payment or session charge at the beginning of each office visit. I agree to pay interest in the amount of 1.5% per month (18% annual interest) on all balances over 60 days past due. In the event that Dr. Jessica Gurvit, Psy.D., P.A. & Associates incurs fees for collection costs and/or attorney's fees, I will be responsible for payment of such fees.

Signature on File and Assignment of Benefits:

I understand that this office utilizes computerized billing and collection services. My signature below, whether by photocopy or fax authorizes the release of any payment and protected health information (medical information) necessary to process my or my family member's claims. I authorize payment directly to Jessica M. Gurvit, Psy.D., P.A., & Associates, for the insurance benefits otherwise payable to me or my family for professional services.

Name: _____

Address: _____

_____

Phone #: _____

Signed: _____ **Date:** _____

*** **The portion of your payment not reimbursed by insurance is required on the date of your visit.** **If not paying by cash or check, our office now requires a MasterCard or Visa on file. We do not bill. Thank you.**

CREDIT CARD AUTHORIZATION

DATE: _____

TO: DR. JESSICA M. GURVIT, PSY.D. P.A. & ASSOCIATES

FROM: _____

RE: AUTOMATIC PAYMENT AUTHORIZATION

Please accept this completed form as authorization to bill my

Visa MasterCard

ACCOUNT NO# _____ **EXP DATE**_____

3 DIGIT NO#_____ **RIGHT SIDE OF SIGNATURE PANEL (BACK OF CARD)**

For therapy sessions in the amount of $_____ **as they occur, for the following patient(s)**

_____

_____

This authorization will remain in effect until such time as it is revoked in writing.

I certify that I am an authorized signer of the account number provided.

_____
NAME as it appears on card

_____
Signature **Date**

Submit

Space for any Additional Information

Submit