MARC D. RICHTER, LICSW, LADC

Welcome to My Practice

2 Church Street
Suite 3G
Burlington, VT 05401
866-429-2074 VM
802-540-8199 fax
www.marcrichter.org

The information described below is offered to anticipate the most frequently asked questions about my professional services and business practice. Please read it carefully. If you have questions, it is important that you clarify them with me prior to signing.

Professional Fees & Appointments: Individual, Couples and Family sessions are billed at a rate of $145 per hour; Group sessions - $60 per session. All therapy sessions are 50-53 minutes, except group sessions, which are 80 minutes. I set time aside specifically for your session. In the event that you must cancel an appointment, please call me at least 24 hours in advance. Please do not e-mail, as this is an inadequate means of notification. Failure to give adequate notice will result in your being billed my full appointment fee (excluding Medicaid covered clients). Insurance companies, including Medicaid, will only pay for services rendered and cannot be billed, nor will they reimburse for no-shows or late cancelations.

Miscellaneous Service Charges*:* Please be advised that therapist time spent on client-related professional services outside of the therapy session is not billable to insurance. These services include but are not limited to: report writing, written assessments, court diversion/Dept. of Corrections written evaluations, phone consultations with clients or others (exceeding 15 minutes); face to face consultations with others such as attending school IEP meetings (exceeding 15 minutes), etc. Utilizing the above rates as a guide, this time is billed directly to the client and is pro-rated in quarter hour units (with the minimum of 15 minutes) charged at the quarter hour rate. *This excludes time spent writing customary outpatient treatment reports (OTR's) or other similarly related paperwork required by insurance.*

Confidentiality: Privacy and confidentiality are important to the relationship between client and therapist. There is legal and ethical protection for the information that you share with your therapist and it cannot be released without your express written consent. This also covers my written record. There are exceptions to confidentiality that include but are not limited to: when there is reason to believe that you intend to harm yourself or another person; when a child, elder or disabled adult has been or might be abused or neglected; or if information has been requested by a judge's court order. If you have any questions about confidentiality, now or at any time, prior to or even following treatment, please by all means raise those concerns with me immediately. Your trust and your confidentiality is of the utmost importance to me.

Confidentiality and Insurance Companies: If you will be using benefits under a managed care plan including Medicaid, I may be required to provide information related to your case to the managed care reviewer and your primary physician, in writing and verbally. I will follow these procedures unless otherwise notified by you in writing. I acknowledge the use of a billing service (Claims Connection) located in Plattsburgh, NY to bill for those charges to be issued to my insurance company. When technology permits, these claims may be submitted electronically. Signing below is an acknowledgement that Claims Connection will be given a copy of your "Client Information Form" page (included in this intake packet) in order to process these claims and/or to maintain a record of your account. Signing below also acknowledges that you are authorizing Claims Connection to contact your insurance company to check on claims submitted for payment for services. I hereby authorize my insurance benefits to be paid directly to Marc Richter, PLLC and acknowledge that I am financially responsible for any unpaid balance. I also authorize the release of information needed to verify the medical necessity for my evaluation and treatment to my insurance.

If your insurance coverage changes, YOU are responsible for immediately notifying me of the change.
Remember, you are ultimately responsible for fees not covered by your insurance.

Consent for Treatment: I voluntarily consent to clinical evaluation/ treatment for my minor child or myself. I understand that there are both benefits and risks involved with engaging in psychotherapy and that there are no guarantees about the outcome.

My signature below indicates that I have had an opportunity to ask and have my questions answered about the above information and I have read, understand and agree to abide by all of the above outlined terms.

Signature _____ _____ _____
Client Signature | Print Name of Client | Date

Signature _____ _____ _____
Signature of Parent or Legal Guardian | Print Name of Parent or Legal Guardian | Date

Witness Signature _____ _____ _____
Witness Signature | Printed Name | Date

MARC D. RICHTER, LICSW, LADC

Client Information Form

Client Name _____

Street Address _____

City/State/Zip _____,VT _____

Social Security #____-____-_____ Date of Birth____/____/____

Contact Info:

Home _____
Work _____
Cell _____
Email _____

Name of Guardian/Parent (if applicable): _____ Phone: _____
Emergency Contact: _____ Phone: _____
PCP/Pediatrician: _____ Phone: _____

Who referred you to my office? ☐Doctor? ☐Another therapist? ☐Other? Their name? _____

PRIMARY Insurance Company & PHONE #: _____

Certificate # _____ Group # _____

_____ ____-____-____ ____/____/____
Policy Holder Name (if different from client) Social Security # Date of Birth

_____ _____ _____
Street Address City / State Zip code

Place of employment: _____ Amount of Copay: _____

Relationship to client: □ Self □Spouse □Child □Other _____

SECONDARY Insurance Company & PHONE #: _____

Certificate # _____ Group # _____

_____ ____-____-____ ____/____/____
Policy Holder Name (if different from client) Social Security # Date of Birth

_____ _____ _____
Street Address City / State Zip code

Relationship to client: □ Self □Spouse □Child □Other _____

Responsible party for payment for services not covered by insurance:

Name: _____

_____
Street Address (if different from client) City / State Zip code

Please Sign here → _____
Signature of responsible party

For Office Use Only

First DOS: ____/____/201____

DX Code: _____

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PRIMARY CARE PHYSICIAN CONSENT FORM

Communication with your primary care provider (PCP) can be important to make sure all care is complete, comprehensive and well coordinated. This form allows for that exchange of information. I do not release information without your signed authorization.

CLIENT & PCP INFORMATION

Name _____ SS # or ID# _____ D.O.B. ___/___/___

Insurance _____

Referred By: Self _____ Other: _____

Name of Physician _____ Facility / Practice Address _____

Phone number ( ) - _____ Fax number ( ) - _____

CLIENT Consent to Communicate with Primary Care Physician

I understand that my records are protected under the applicable state law governing health care information that relates to mental health services under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records 42 CFR Part 2, 45 C.F.R. parts 160 & 164 and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and prohibits any further disclosure by the designated recipient of this information unless expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. I have not been coerced to sign this authorization. I understand that I might be denied services if I refuse to consent to a disclosure for the purposes of treatment, payment, or health care operations, if permitted by state law. I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits nor will I be denied services if I refuse to consent to a disclosure for other purposes. I understand that prepayment for copies of my records as well as payment for services rendered may be required for copies of my record when released to anyone other than a medical provider, facility or institution. I understand that by signing this form I am confirming my authorization for use and/or disclosure of the protected health information described above with the people and/or organizations named above. I have read this release and understand its contents. I have also been provided a copy of this form. I also understand that I may revoke this consent at any time by notifying the provider in writing (except to the extent that action has already been taken in reliance on it). This release will automatically expire twenty-four (24) months from the date signed below or upon the date specified here _____.

I, _____ hereby authorize **Marc D. Richter, LICSW, LADC** to:
(PRINT name of patient/client)

CLIENT PLEASE CHECK ONE: ☐ **NOT** release any applicable information to my physician.
☐ release applicable information to my physician.

Print Name of Client _____ Signature of Client _____ Date signed ___/___/___

I, _____ hereby authorize **Marc D. Richter, LICSW, LADC** to::
(PRINT name of parent/legal guardian)

PARENT/LEGAL GUARDIAN PLEASE CHECK ONE: ☐ **NOT** release applicable information to the child's physician.
☐ release applicable information to the child's physician.

Print Name of Parent or Legal Guardian _____ Signature of Parent or Legal Guardian _____ Date signed ___/___/___

TO BE FILLED OUT BY PROVIDER

Reason for Report: *(to be completed by Marc)*

Initial Report ☐ Treatment Update ☐ Discharge ☐ Other ☐ _____

Treatment Information: *(to be completed by Marc)* Diagnosis: _____

Presenting Problem: _____

Type / Dosage of Psychotropic Medication: _____ MD _____

Type / Frequency of treatment: Weekly ☐ Bi Weekly ☐ Monthly ☐ Other ☐: _____

Mental Health Care Provider Information:

Marc D. Richter, LICSW, LADC _____ ___/___/___
Signature Date

MARC D. RICHTER, LICSW, LADC

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I _____ , on behalf of My Self , hereby
(name of client or authorized representative (i.e.: parent, guardian…)) (if applicable write minor's name or write "my self"

authorize Marc D. Richter , Networks Inc. to: ✔ Request & receive the following indicated pertinent & relevant information;
(name of provider)

_✔_ Disclose or release the following indicated pertinent & relevant information;

To/From: **Marc D. Richter, PLLC, Marc Richter, LICSW, LADC, 2 Church St., Suite 3G, Burlington, VT 05401, Phone: (866) 429-2074**
(Name of provider)

Please **INITIAL** *each line as applicable below:*

_____ My Mental Health Record in its Entirety,

_ ___ My Substance Abuse Record in its Entirety,

OR ~~***Only the following information:***~~

___ ~~Substance use/abuse history~~	___ ~~Diagnostic summary and diagnoses~~	___ ~~Social/Family history~~
___ ~~Psychological Evaluations~~	___ ~~History of Medical Treatment~~	___ ~~Legal History~~
___ ~~History of Psychiatric Treatment~~	___ ~~Intake summary/assessment~~	___ ~~Course and results of treatment~~
___ ~~Treatment Plan(s) or Summary~~	___ ~~Presence/Progress in Treatment~~	___ ~~Demographic Information~~
___ ~~Progress Notes~~	___ ~~Expected length of treatment~~	___ ~~Verbal exchange of information~~
___ ~~Drug & Alcohol Toxicology Screens~~	___ ~~Attendance records only~~	___ ~~Evaluations (substance abuse, mental health)~~

_____ **I understand that the information released may include information pertaining to substance abuse and/ or dependence.**
_____ **I understand that the information released may include information pertaining to HIV infection, AIDS or tests for HIV.**

The purpose of the disclosure authorized by this consent is: **to facilitate transfer of my entire client written record.**

I understand that (if applicable) my alcohol / drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 C.F.R. Part 2) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. parts 160 & 164 and cannot be disclosed or further re-disclosed by the designated recipient of this information unless expressly permitted by the written consent of the person to whom it pertains, or unless otherwise provided for in the regulations. I also understand that my behavioral health records are confidential and protected from unauthorized disclosure. I understand that if the person or entity that receives this information is not a health plan or health care provider covered by federal privacy regulations, the released information may be re-disclosed by the recipient and may no longer be protected by federal/state law.
I understand that I may revoke this authorization/consent at any time by notifying the provider in writing, except to the extent that action has been taken in reliance on it. Thus, I understand that my revocation will not affect any actions taken by my provider before receiving my written revocation.

This consent/authorization shall be valid for one year from the date below and shall expire two (2) years from the Date of Signature below **or** upon the *date*, *event*, or *condition* noted here, **or** unless sooner revoked in writing: _____.

I have not been coerced to sign this authorization. I understand that I might be denied services if I refuse to consent to a disclosure for the purposes of treatment, payment, or health care operations, if permitted by state law. I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits nor will I be denied services if I refuse to consent to a disclosure for other purposes. I understand that prepayment for copies of my records as well as payment for services rendered may be required for copies of my record when released to anyone other than a medical provider, facility or institution.

I understand that by signing this form I am confirming my authorization for use and/or disclosure of the protected health information described above with the people and/or organizations named above. I have read this release and understand its contents. I have also been provided a copy of this form.

_____	_____	_____	_____
Signature of Client	**Print Name of Client**	**DOB**	**Date of Signature**

Print Name of Personal Representative or person signing for client: _____

Relationship to client (parent, guardian, etc.)/Authority to sign: _____

Signature of Personal Representative: _____ Date: _____