Robert S. Tasoff, Ph.D.
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Burbank, Ca. 91502

TREATMENT CONSENT INFORMATION FORM

The purpose of this information sheet is to acquaint you with the policies and procedures of my office. Please read and sign this form. To protect your best interests and personal rights, I would like you to be aware that professional ethics and law dictate whatever you say in a psychotherapy session (Protected Health Information or PHI) will remain confidential and will not be shared with anyone without your written permission with some exceptions. The following policies outline the uses and disclosures of your PHI. Please refer to the **Notice of Privacy Practices** located in my office.

1. HOW I MAY USE AND DISCLOSE YOUR PHI WITHOUT WRITTEN CONSENT

- Relating to treatment
- To obtain payment for treatment
- For health care operations
- Emergency treatment
- When disclosure is required by federal, state or local law; judicial or administrative proceedings; or law enforcement
- For public health activities
- For health oversight activities
- For research purposes
- To avoid harm
- For specific government functions
- For workers' compensation purposes
- Appointment reminders and health related benefits or services.
- I am required to furnish PHI to an agency, if you have been referred to me by an agency, HMO, PPO, or other third party payor,
- If you are under the age of 18, your parents or legal guardians have the right to be informed of your psychological condition, progress & treatment.

2. CERTAIN USES AND DISCLOSURES REQUIRE YOU TO HAVE THE OPPORTUNITY OBJECT (disclosures to family, friends, or others).

3. OTHER USES AND DISCLOSURES REQUIRE YOUR PRIOR WRITTEN AUTHORIZATION

(Any other situation not described in sections III A, B & C in the **Notice of Privacy Practices).**

4. PATIENT RIGHTS

Although your health record is the physical property of *Robert S. Tasoff, Ph.D.,* you have the following rights with regard to the PHI contained therin:

- The right to request to limits on uses and disclosures of your PHI.
- The right to choose how I send PHI to you.
- The right to see and get copies of your PHI.
- The right to get a list of your disclosures I have made.
- The right to correct or update your PHI.
- The right to get this notice by email.

5. APPOINTMENTS

Appointments are scheduled directly through me. **If you are unable to keep an appointment, you will need to cancel a minimum of 24 hours in Advance. You, *not the insurance company*, will be responsible for payment in full if you do not cancel in advance or if you do not show for your Appointment. I cannot bill insurance companies for missed appointments.**

6. EMERGENCIES

If you have a ***true emergency situation***, you may contact me by leaving a voice mail on my office telephone number, which is (818) 567-2015. Pressing #2 after your message will page me and I will return your call as soon as possible. When I am unavailable, an emergency contact will be listed on my office message machine. Due to the possibility of technological malfunction, the quickest and safest way to get attention for emergencies is to dial **9-1-1.**

7. YOUR SIGNATURE BELOW INDICATES THE FOLLOWING:

- I have read and I understand these procedures.
- I authorize treatment of myself, or the dependent indicated as the patient.
- I understand that if *Robert S. Tasoff, Ph.D.,* requests authorization for additional sessions from my managed care company, the medical necessity for further treatment and the effectiveness of treatment already provided will be weighed.
- I authorize *Robert S. Tasoff, Ph.D.* to release the required information in order to process claims with my payor.
- I authorize communication between *Robert S. Tasoff, Ph.D.* and other attending health care providers for coordination of care.
- I authorize *Robert S. Tasoff, Ph.D.* to communicate the above-mentioned PHI, in accordance with my **Notice of Privacy Practices,** in person, by telephone, by written material, email, or by facsimile. Once PHI leaves my office I relinquish any liability arising from their release.
- I understand that I have the right to formally appeal decisions regarding authorized treatment services by first contacting *Robert S. Tasoff, Ph.D.*. I further understand I have the right to submit a complaint or grievance to *Robert S. Tasoff, Ph.D.* regarding any aspect of my care, or I may submit complaints to my health plan. I understand I risk nothing in exercising these rights.
- A photocopy of this release is considered as valid as the original.
- This authorization is subject to revocation by me at any time except to the extent that action has been taken in reliance hereon.

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Patient/Responsible Party (please print)

____ ____________________________
Patient/Responsible Party (SIGNATURE) Date