Laura Curtiss Feder, PsyD

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Registration Form

Name:

(If different) I prefer to be called:

Referred by:

Today's date:

Name and telephone # of Internist/GP/Family Practitioner:

Date of last physical exam:

Personal Data:

Date of Birth: Age:

Email address: ❒ OK for Dr. Feder to email you

Address (include zip code):
Home: Work:

Telephone Numbers: ❒ OK for Dr. Feder leave message

Home: Work:

Cell: ❒ OK for Dr. Feder to text message you
In case of emergency, contact:

Name: _____ Relationship: _____

Contact number: _____

Please list your **immediate family's** names, ages, and relationship to you:

Please list the name, age, and relationship to you of **anyone residing in your household**:

Gender: _____

How would you identify your current **sexual orientation?** _____

What is your current **romantic relationship** status? _____

Where were you **born**? _____

What is your **ethnic background**? _____

Do you currently practice a **religion**? (please circle): YES NO

If yes, please describe: _____

Did you practice a **religion growing up**? (please circle): YES NO

If yes, please describe: _____

What is your **current occupation**?: _____

What is the **highest level of education** you have completed: _____

Are you **currently attending school**? (please circle): YES NO

(If yes, specify name of school):_____

(If yes, what is your major or focus of study?): _____

Have you ever been diagnosed with a **learning disorder**?: YES NO

Medical Data:

Please list **all** current medications (including over-the-counter/non-prescribed meds like aspirin, sleeping meds, etc.) taken during the past 30 days:

Medications	Dosage	Time of Last Dose	Prescribed by:

Please list all **current** medical problems and allergies:

Please list all **past** medical problems:

Please List all **Past Hospitalizations** (Medical, OB/GYN, Psych, Orthopedic etc.):

Date	Hospital	Reason for Hospitalization	Length

Current and **Past Psychiatric/Psychological Treatments**:

Date	Place	Therapist/M.D.	Length	Nature of Treatment

Please list names, addresses and telephone numbers of current and previous therapists and physicians:

Are you currently part of any 12-step programs or fellowships? If so, please describe:

Do you see any other healthcare practitioners (e.g., nutritionist, acupuncturist, massage therapist)? If so, please describe:

Please sign below to authorize Dr. Laura Curtiss Feder to contact previous therapists or physicians in order to obtain a complete medical history in compliance with HIPAA laws concerning confidentiality.

_____ _____

Patient's signature Date

CURRENT SYMPTOMS

Do you use **alcohol**? YES NO How much?

Do you use **other substances (including nicotine)**? YES NO

What substances? How much?

Is there anyone in your **family with a history of substance abuse or addiction** YES NO

If so, please describe:

Do you have any history of **eating disorders** (binging, purging or restricting)? YES NO

If so, please describe:

Do you have any history of **other addictive or reckless behaviors** (e.g., sex, viewing porn, gambling, spending)? YES NO

If so, please describe:

Are there other **uncontrollable thoughts behaviors you cannot stop**? YES NO

Do you any history of violence or interaction with the **legal system**? YES NO

If so, please describe:

Do you have any history **of self-harm** (e.g., burning, cutting yourself)? YES NO

If so, please describe:

Have you ever **attempted suicide**? YES NO

Have you ever had **thoughts of suicide**? YES NO

If yes to either of the above, please describe:

Do you **see or hear things that others around you say they do not**? (circle) YES NO

Were you ever the **victim of abuse or violence** (e.g., sexual, physical or other) YES NO

If so, please describe:

Is there anyone in your **family with a history of mental illness**? YES NO

If so, please describe:

BILLING INFORMATION AND CREDIT CARD AUTHORIZATION

Fees are discussed in an initial consultation, if not already established when scheduling your first session.

Your fee is: $_____ per session

I prefer patients to pay by check, but also accept cash, credit cards and Venmo.

Payment is due at the time of service. I ask all patients to keep an active credit card on file unless they opt to pay at each session by check or cash. If a bill has not been paid in full within 30 days of the last session, the card on file will be charged.

For regular patients who prefer, I can arrange for billing and payment at the end of the month. Statements can be provided to you in person, via email or to someone else paying on your behalf.

I do not accept insurance, but many plans offer out-of-network coverage. An FAQ sheet about insurance plans and mental health is provided on the next page. If you have out-of-network reimbursement, the statements I provide to you should contain all of the necessary information and you can send them directly to your insurance company.

Your psychotherapy sessions are eligible for reimbursement or payment from a Healthcare Savings Account. I can accept HSA cards or provide invoices that are eligible for your reimbursement.

Party responsible for billing: _____

Name as it appears on the credit card; _____

Type of credit card (American Express, Visa): _____

Credit card number: _____

Date of expiration:_____

The credit card code verification (CCV) digits are (4 numbers on the front of AMEX card or 3 digits on back of VISA/MASTERCARD: _____

Credit card mailing address: _____

Please sign your name and write today's date:

_____ _____

Patient's signature Date

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Insurance Frequently Asked Questions

- ❒ Do I have mental health (or behavioral health) benefits?
- ❒ Does my plan offer coverage for an out-of-network psychologist?
- ❒ How much will I be reimbursed per single therapy session (CPT code 90834)?
- ❒ If they mention something about reimbursing a percentage of the "usual and customary" rate, as what the “usual and customary rate” is for a session with a psychologist in Manhattan (zip code 10023)?
- ❒ How many sessions per calendar year, or what total dollar amount per year, does my plan cover for a psychologist?
- ❒ What is my out of network deductible and has it been met? (Does it re-set in each calendar year?)
- ❒ Is pre-certification required for me to meet with a psychologist?

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NOTICE OF PRIVACY PRACTICES

Federal regulations known as "HIPAA" require all health care providers to provide patients with a written notice about their privacy practices. Because of the confidential nature of the psychotherapeutic relationship, the privacy of your mental health information is especially important. My notes are kept confidential and will not be revealed to others without your written consent. This includes communications with other professionals, insurance companies, your family, and friends. There are, however, a few exceptions:

- I am required by law to report suspected child and elder abuse or neglect.
- If you tell me that you intend to harm another person, I am required by law to try to protect that person. This may involve telling that person, another health care provider, or law enforcement personnel.
- Similarly, if you threaten to harm yourself, I will try to protect you by telling others, including, but not limited to, your relatives, other health care providers, or the police, who can assist in protecting you.
- If you are involved in certain court proceedings, I may be required by law to reveal information about your treatment. These situations include child custody disputes, cases where a therapy patient's psychological condition is an issue, lawsuits, formal complaints against the therapist, civil commitment hearings, and court-ordered treatment.
- If your health insurance or managed care plan will be reimbursing you or paying me directly, they will require that you waive confidentiality so that I can give them pertinent information about your treatment.

Please understand that in all of the above situations, I will try to discuss the specific situation with you before any confidential information is revealed, and I will reveal only the least amount of information that is necessary.

YOUR INDIVIDUAL RIGHTS

- You may request access to your record, in writing, in order to inspect and request copies of the record. I am required to respond to you within 10 days. I may charge a fee for the costs of copying and sending you any records required. In certain cases, I may deny access to your record. You may appeal my decision to the Medical Records Review Committee of the New York State Department of Health or Massachusetts Board of Psychology.
- You have the right to request amendments to your psychotherapy record. Such requests must be in writing and must state the reason for the requested amendment. I may deny your request under certain circumstances.
- You have a right to obtain a copy of this notice. I reserve the right to revise this notice. I will make available to you any revised notice.
- If you desire further information about your privacy rights, or are concerned that I have violated your privacy rights, you may speak with me. You may also file a complaint with the Secretary of the Department of Health and Human Services of the United States. No retaliatory action will be taken against you for any complaint you may make.

COMMUNICATION METHODS

You can reach me by several methods. Please note that the security of these methods varies. If you wish to discuss something, please call me on the phone. If you wish to transmit a document, please send it by postal mail or email marked confidential. Email and text messages are not secure methods of communication. These can only be used to discuss routine matters, such as scheduling. I cannot guarantee the security of these communications. By communicating with me in these ways, you assume all risk related to associated compromises in confidentiality.

Please retain this document for your records or recycle if you choose

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INFORMED CONSENT/PRACTICE POLICIES/FEE FOR ADULT PSYCHOTHERAPY

Now that we are meeting for an initial consultation, you may have questions about what to expect from therapy. Please feel free to ask questions at any time.

As we have established together, your fee for each session is $_____.

In order to maintain my ability to provide services, I must require all patients to be responsible for the time set aside for their use. My policies are as follows:

- I require 48 hours' (2 business days') notice for a cancellation, otherwise you will be charged the full session rate if we are unable to reschedule.
- If you have health insurance that you would like to utilize, you can receive reimbursement by submitting your monthly bill to your insurance company.
- We will discuss whether payment will be due at each session or at month's end.
- I accept cash, checks and credit cards (including healthcare spending account cards). In the event that the portion your bill for which you are responsible is unpaid for longer than 30 days and no other arrangements have been made, the credit card on file will be charged the amount of your balance. Check is preferred.
- Checks will be made out to Laura Curtiss Feder, PsyD.
- In order to provide you the best care possible, your case may be used for educational purposes and discussed, verbally or in writing, without revealing your name or other specific identifying information outside of our sessions.
- Your signature below indicates your informed consent and also that, if desired, you have received a copy of this form and a Notice of Privacy Practices and have been provided with the opportunity to ask questions about it.
- Per HIPAA regulations, your record is private and circumstances in which I may break confidentiality include risk to yourself, threat to another person, report of abuse of a minor or elder, court order, and contact with your insurance company.
- Your signature below also indicates your understanding of the limited security of email and text messaging and you assume all responsibility for said risks.

Please understand that in all of the above situations, I will make every effort to discuss the specific situation with you before any confidential information is revealed, and will reveal only the least amount of information that is necessary.

Print Name: _____

Signature: _____ Date: _____