You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If I have reasonable cause to believe that a child has been abused or neglected, I am required by law to report such information within 24 hours to the NYC Administration for Children's Services.
-
- **Adult and Domestic Abuse:** If I have reasonable cause to believe that an elderly or disabled adult has been abused, neglected, or exploited, I am required by law to report this information to the county adult protective services provider .

- **Health Oversight:** If the New York State Board of Psychological Examiners issues a subpoena, I may be compelled to testify before the Board and produce your relevant records and papers.

- **Judicial or administrative proceedings:** If you are involved in a court proceeding and a request is made for information about the professional services that I have provided you and/or the records thereof, such information is privileged under state law, and I must not release this information without written authorization from you or your legally appointed representative, or a court order. This privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. I will inform you in advance if this is the case.

- **Serious Threat to Health or Safety:** If you communicate to me a threat of imminent serious physical violence against yourself or a readily identifiable victim and I believe you intend to carry out that threat, I must take steps to warn and protect. I also must take such steps if I believe you intend to carry out such violence, even if you have not made a specific verbal threat. The steps I take to warn and protect may include arranging for you to be admitted to a psychiatric unit of a hospital or other health care facility, advising the police of your threat and the identity of the intended victim, warning the intended victim or his or her parents if the intended victim is under 18, and warning your parents if you are under 18.

- **Worker's Compensation:** If you file a worker's compensation claim, I may be required to release relevant information from your mental health records to a participant in the worker's compensation case, a reinsurer, the health care provider, medical and non-medical experts in connection with the case, the Division of Worker's Compensation or the Compensation Rating and Inspection Bureau.

IV. Patient's Rights and Psychologists Duties

Patient's Rights:

- *Right to Request Restrictions* - You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.

- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* - You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address.)

- *Right to Inspect and Copy* - You have the right to inspect or obtain a copy (or both) of PHI and psychotherapy notes in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.

- *Right to Amend* - You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request I will discuss with you the details of the amendment process.

- *Right to an Accounting* - You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice.) On your request, I will discuss with you the details of the accounting process.

- *Right to a Paper Copy* - You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Psychologist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.

- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.

- If I revise my policies and procedures, I will notify you in person or by mail.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact me, James Battaglia at 646-45-3377

If you believe that your privacy rights have been violated and wish to file a complaint with me, please contact:

New York's Professional Misconduct Enforcement System
Complaint Hot Line:
1-800-442-8106 or conduct@mail.nysed.gov

You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date

This notice has gone into effect on the date signed.

Your signature on the signature page acknowledges that you have read and understood the information in this document and agree to abide by its terms during our professional relationship.

Acknowledgement of Receipt of HIPAA Notice

By your signature below, you indicate that you have received a copy of the "Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information" from James F. Battaglia, Ph.D.

_____ _____
Signature of Patient if 14 years or older Date

_____ _____
Print your name above Birthdate

_____
Signature of Parent/Guardian if pt. is under 18 years

_____
Signature of other Parent/Guardian if Joint Custody

Form IV - Health Insurance Claim Form

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

CARRIER

1. MEDICARE MEDICAID TRICARE CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) (Medicare#) (Medicaid#) (SSN or ID#)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) YES NO

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd. for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

Form V - Cancellation Policy

JAMES F. BATTAGLIA, PH.D
360 W 43rd Street, Apt. S9E
New York, NY 10036
646-544-3377
docjb.com

CANCELLATION POLICY AGREEMENT

I understand the following office policy regarding cancellation or failing to attend a scheduled appointment:

1) When cancelling an appointment, I must give more than 24 hours notice. I understand there are exceptions, including illness and emergencies.
   a. If a cancellation is made less than 24 hours before the scheduled appointment, the reserved time may be forfeited and I may be placed on the waiting list until another time slot opens.
   b. If two appointments are canceled without giving 24 hours notice, the reserved time may be forfeited and I may be referred to another provider.

2) I understand my credit card information is to be kept on file with Dr. Battaglia in a secure place. If an appointment is cancelled without the 24 hour prior notice, Dr. Battaglia will take that as consent to charge the session fee to my credit card. Therefore, I have provided my credit card information below along with my consent that the missed session's fee be charged to the card.

3) I understand that when a cancellation is made within the required time frame, Dr. Battaglia will do his best to reschedule me for the same week. I am aware that this may not be possible.

4) When canceling or rescheduling an appointment, I agree to contact Dr. Battaglia by text at 201-755-0767 or email me at dr.jb.psychologist@gmail.com .

I agree to the above.

Signed: _____

Date: _____

_____

Please Print:

Name on Credit Card: _____

Credit Card Number: _____

Expiration Date: _____ CVV Code: _____