JAMES F. BATTAGLIA, PH.D.
PSYCHOLOGIST
601 W 57TH STREET, SUITE 37A
NEW YORK, NY 10019
646-455-3377

WELCOME TO THE PSYCHOLOGY PRACTICE OF
DR. JAMES F. BATTAGLIA

Beginning therapy is a significant step—whether it's your first time or you are returning to the process. It is completely natural to feel a mix of curiosity, uncertainty, or even hesitation as we begin.

The materials in this packet are designed to orient you to my practice and help us build a shared understanding of your goals. Some documents are required for legal and ethical reasons, while others offer you space to reflect on your history and what you hope to achieve.

What's inside this packet:

- **Informed Consent:** Details on how psychotherapy works and my practice policies.
- **Intake Form:** Background information to help me understand your journey.
- **Privacy Practices (HIPAA):** How your personal information is protected.
- **Logistics:** Information regarding billing, insurance, and cancellations.

Please complete what you can before our first session. If any question feels uncomfortable or unclear, feel free to leave it blank—we can explore those together when we meet. I look forward

Dr. B

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INFORMED CONSENT FOR PSYCHOTHERAPY – 2026

This document constitutes the Informed Consent for Psychotherapy.

Purpose of This Document

This document is intended to help you understand the nature of psychotherapy, your rights as a patient, and the policies that guide my practice. Please read it carefully and feel free to ask questions at any time. Your signature indicates that you understand this information and agree to participate in psychotherapy under these conditions.

Nature of Psychotherapy

Psychotherapy is a collaborative process that involves discussion, reflection, and exploration of thoughts, feelings, behaviors, and relationships. The goals of therapy vary from person to person and may change over time. Therapy can be helpful, meaningful, and at times challenging. It may involve emotional discomfort as well as insight and relief.

While I will bring my training, experience, and professional judgment to our work, therapy requires your active participation and engagement. Progress is influenced by many factors, including your commitment to the process and the fit between therapist and patient.

You are free to discontinue therapy at any time. If you have concerns about our work together, I strongly encourage you to discuss them with me so they can be addressed directly.

Confidentiality

The relationship between psychologist and patient is confidential and protected by law and professional ethics. Information shared in therapy is not disclosed to others without your written authorization, except in specific circumstances required or permitted by law.

Limits to confidentiality include, but are not limited to:
• Situations involving risk of serious harm to yourself or others
• Suspected abuse or neglect of a child, elderly person, or dependent adult
• Court orders or legal proceedings that require disclosure
• Certain insurance, billing, or administrative requirements

If therapy is funded through insurance or a third party, limited information may be shared asrequired. Whenever possible, I will make reasonable efforts to discuss such disclosures with you.

Records and Privacy

I maintain clinical and billing records in accordance with professional standards and legal requirements. You have the right to request access to your records, subject to certain limitations. Psychotherapy notes receive additional legal protection. A detailed explanation of privacy practices is provided in the HIPAA Notice included in this packet.

Session Structure

Individual psychotherapy sessions typically last **45–60 minutes**, unless otherwise agreed upon. Group therapy sessions last longer. Sessions are scheduled at mutually agreed times, and consistency is encouraged to support the work.

Fees, Billing, and Insurance

Payment is due at the time services are rendered. Information regarding fees, insurance participation, and billing procedures is provided separately.

If you use insurance, you are responsible for understanding your coverage, including deductibles and out-of-network benefits. Ultimately, payment for services is your responsibility. I am available to provide documentation or clarification as needed.

Communication Between Sessions

If you need to contact me between sessions, you may do so by phone or email. Matters that require extended discussion are best addressed during scheduled sessions. Time spent on phone calls or other clinical communications may be billed in accordance with professional guidelines.

In case of an emergency, please call 911 or go to the nearest emergency room.

Cancellations and Missed Appointments

Session times are reserved specifically for you. If you need to cancel or reschedule a session, **at least 48 hours' notice** is requested. Cancellations made with less than 48 hours' notice, as well as missed appointments, are charged the full session fee.

Details regarding cancellations and fees are outlined in the separate **Cancellation Policy** included in this packet.

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PATIENT INTAKE FORM 2026

Please fill in the information below and bring it with you to your first session.
Information provided on this form is protected as confidential information.

Personal Information

Name: _____ Date: _____

Address: _____

City _____ State:_____ Zip:_____

Phone: _____ Email: _____

**Please note:* *Email correspondence is not considered to be a confidential medium of communication.*

DOB: _____ Age: _____

Marital Status

□ Single □ Married. □ Divorced □ Separated

Sexual Orientation

☐ Heterosexual / Straight ☐ Gay / Lesbian ☐ Bisexual

☐ Questioning ☐ Other _____ ☐ Prefer not to answer

Height: _____ Weight: _____

Origin:

City: _____State:_____ Country (if other than US) _____

Education or Training

☐ Some high school or equivalent

☐ Some college or training ☐ Associate degree

☐ Bachelor's degree ☐ Graduate or professional degree

Schools Attended: _____

Emergency Contact

Name: _____

Phone: _____Relationship: _____

Referred By (if any): _____

Reasons for Seeking Therapy

_____

_____

_____

HISTORY

General and Mental Health Information

1. How would you rate your current physical health? (Please circle one)

   Poor Unsatisfactory Satisfactory Good Very good

2. Please list any specific health problems you are currently experiencing

   _____

3. Have you previously received any type of mental health services (psychotherapy, therapy services, etc.)? □ No □ Yes, previous therapist/practitioner: _____

4. Are you currently taking any prescription medication? □ No □ Yes, If Yes, please list medication(s) and doses:

_____

_____

5 How would you rate our current sleeping habits (Please circle one)

Poor Unsatisfactory Satisfactory Good Very good

6 Please list any specific sleep problems you are currently experiencing:

_____

_____

7 How many times per week do you exercise? _____

What types of exercise do you do?

_____

8 Please list any difficulties you experience with your appetite or eating problems:

_____

9 Are you currently experiencing overwhelming sadness, grief or depression?

□ No □ Yes If Yes, for approximately how long? _____

10 Are you currently experiencing anxiety, panics attacks or have any phobias?

□ No □ Yes If Yes, when did you begin experiencing this? _____

11 Are you currently experiencing any chronic pain? □ No □ Yes

If Yes, please describe: _____

12 Do you drink alcohol? □ No □ Yes If Yes, how many drinks per week? _____

13 Do you use recreational drugs? □ No □ Yes If Yes,

What? _____ How Often?_____

14. Are you currently in a romantic relationship? □ No □ Yes

If Yes, for how long? _____

15. On a scale of 1-10 (with 1 being poor and 10 being exceptional), how would you rate your relationship?

1 2 3 4 5 6 7 8 9 10

16. What significant life changes or stressful events have you experienced recently?

_____

_____

Family Mental Health History

If applicable, please indicate any family history of mental health problems and note the family member's relationship.

Condition	Family Member	How Long?
Alcohol/Substance Abuse		
Anxiety		
Depression		
ADHD		
Domestic Violence		
Eating Disorders		
Obesity		
Obsessive Compulsive Behavior		
Suicide or Suicide Attempts		

Additional Information

1. Are you currently employed? □ No □ Yes

2. Where do you work? What is your job?

_____

_____

3.

3. Do you enjoy your work? Is there anything stressful about your current work?

_____

_____

4. Do you consider yourself to be spiritual or religious? □ No □ Yes

   If Yes, describe your faith or belief: _____

5. What do you consider some of your strengths?

_____

_____

6. What do you consider some of your weaknesses?

_____

_____

7. Have you been in psychotherapy before? No □ Yes If Yes, how long_____

8. What would you like to accomplish out of your time in therapy?

_____

_____

Thank you for taking the time to complete this form!

JAMES F. BATTAGLIA, PH.D.
PSYCHOLOGIST
601 W 57TH STREET, SUITE 37A
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NOTICE OF PRIVACY PRACTICES (HIPAA) – 2026

A brief note before the legal language

This notice explains how your personal health information is protected, how it may be used, and what your rights are. Much of the language below is required by law and may feel formal or detailed. Many patients choose to skim this document, and that is okay. If you have questions now or at any point in our work together, I am happy to discuss them.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may use or disclose your protected health information (PHI) for purposes of treatment, payment, and health care operations, as permitted by law.

- **Treatment** includes providing, coordinating, or managing your psychological care.
- **Payment** includes billing and reimbursement activities.
- **Health care operations** include administrative, legal, and quality-assurance activities related to the operation of my practice.

PHI refers to information in your health record that could identify you.

II. Uses and Disclosures Requiring Authorization

Uses and disclosures of PHI outside of treatment, payment, and health care operations require your written authorization, except where otherwise permitted or required by law.

Psychotherapy notes receive special protection under federal law and are not released without specific authorization, except as required by law.

You may revoke an authorization in writing at any time, except where action has already been taken in reliance on that authorization.

III. Uses and Disclosures Without Consent or Authorization

In certain situations, I am legally required or permitted to disclose PHI without your consent, including:

- Situations involving risk of serious harm to yourself or others
- Suspected abuse or neglect of a child, elderly person, or dependent adult
- Court orders or legal proceedings

• Health oversight activities, including licensing or regulatory inquiries
• Workers' compensation or similar claims, as required by law

Whenever possible, I will make reasonable efforts to discuss such disclosures with you.

IV. Your Rights Regarding Your Health Information

You have the right to:
• Request restrictions on certain uses or disclosures of your PHI
• Request confidential communications by alternative means or locations
• Inspect and obtain a copy of your health records, subject to legal limitations
• Request amendments to your health information
• Receive an accounting of certain disclosures
• Obtain a paper copy of this notice upon request

V. My Responsibilities

I am required by law to maintain the privacy of your PHI and to provide you with this notice of my legal duties and privacy practices. I reserve the right to change these practices as permitted by law. If changes are made, you will be informed.

VI. Questions or Complaints

If you have questions about this notice or concerns about your privacy rights, you may contact me directly:

James F. Battaglia, Ph.D.
646-455-3377

If you believe your privacy rights have been violated, you may also file a complaint with: New

York State Education Department
Office of the Professions
Professional Misconduct Enforcement Complaint
Hotline: 1-800-442-8106

You will not be retaliated against for filing a complaint.

VII. Effective Date

This notice is effective as of **January 1, 2026**.

JAMES F. BATTAGLIA, PH.D.
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646-455-3377

NOTICE OF PRIVACY PRACTICES (HIPAA) – 2026

Acknowledgement of Receipt of HIPAA Notice – 2026

By signing below, you acknowledge that you have received a copy of this Notice of Privacy Practices.

Patient Name (print): _____

Patient Signature: _____

Date: _____

JAMES F. BATTAGLIA, PH.D.
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INSURANCE & BILLING INFORMATION – 2026

A note about insurance and billing

Health insurance can be confusing and frustrating, even for people who deal with it regularly. The information below is intended to clarify how billing works in my practice and to help you understand your role in the process. If something feels unclear, please know this is common and we can review questions together.

Payment for Services

Payment is due at the time services are provided. This applies whether you are using insurance or paying privately.

If you are using insurance, you are responsible for understanding your benefits, including deductibles, copayments, and out-of-network coverage. Ultimately, payment for services is your responsibility, regardless of what an insurance representative may tell you.

In-Network and Out-of-Network Services

I am an in-network provider for certain insurance plans. If I am in-network with your plan, you are responsible for payment until any deductible is met.

If I am not in-network with your insurance, you may still have out-of-network benefits. In those cases, you pay the full fee at the time of service and may submit claims to your insurance carrier for reimbursement.

I am happy to provide documentation to support reimbursement when applicable.

Health Insurance Claim Form (CMS-1500)

A copy of the **CMS-1500 Health Insurance Claim Form** is included in this packet for your use if you are submitting claims for out-of-network reimbursement.

You are only responsible for completing the following sections of the CMS-1500 form:

- **Box 1a, 2, 4, 12, 13**

All other sections of the form are completed by **Dr. Battaglia** or are not applicable and **should be left blank**.

If you are unsure how to complete these boxes, you are welcome to bring the form to session and we can review it together. You are not expected to understand or complete the entire form independently.

Electronic Billing

In many cases, I submit claims electronically on the patient's behalf, which may speed reimbursement. If this option is available to you, we can discuss it during session.

Questions

Insurance policies vary widely. If questions arise, please feel free to raise them. Clarifying billing issues early helps prevent misunderstandings later and supports a smoother therapeutic process.

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CANCELLATION POLICY – 2026

Why this policy exists

Psychotherapy works best when sessions occur consistently and when the time set aside for therapy is treated as protected and intentional. Appointment times are reserved specifically for you, and last-minute changes are difficult to fill. This policy supports the therapeutic frame and allows the practice to function responsibly.

Cancellations and Missed Appointments

If you need to cancel or reschedule a session, **at least 48 hours' notice** is required.

Cancellations made with less than 48 hours' notice, as well as missed appointments, are charged the **full session fee**.

This policy applies regardless of the reason for cancellation, including illness, work conflicts, travel delays, or scheduling difficulties.

Insurance Considerations

Insurance companies do not reimburse for missed or late-cancelled sessions. Accordingly, cancellation fees are the responsibility of the patient. Cancellation fees are charged at the full session rate.

Emergencies and Unusual Circumstances

I recognize that emergencies can occur. We can discuss situations as they arise and the possibility of waiving the fee.

Your Responsibility

By scheduling sessions, you agree to this cancellation policy. If you have questions or concerns about it, I encourage you to raise them early so they can be discussed openly.

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CANCELLATION POLICY – 2026

By signing below, you acknowledge that you have received a copy of this Cancellation Policy.

Patient Name (print): _____

Patient Signature: _____

Date: _____

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I

HEALTH INSURANCE CLAIM FORM

Information is needed for the CMS-1500 Health Insurance Claim Form, which is used to bill insurance companies. This form must be completed for Dr. Battaglia to submit claims to your insurance.

The form is on the next page, please complete *only* Boxes 1a, 2, 4, 12, and 13. All other sections will be completed by Dr. Battaglia or are not applicable.

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) TRICARE CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

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

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

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. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

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

b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ *If yes*, return to and complete item 9 a-d.

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 _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ◀ ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE 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. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. _____ 3. _____

2. _____ 4. _____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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. BALANCE DUE $

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.

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ACKNOWLEDGEMENT OF PRACTICE POLICIES – 2026

I acknowledge that I have received, reviewed, and understand the following documents provided by **Dr. Battaglia**:

- Welcome Letter
- Getting Started Checklist
- Informed Consent for Psychotherapy
- Patient Intake Form
- Notice of Privacy Practices (HIPAA)
- Cancellation Policy
- Insurance & Billing Information

I understand that I may ask questions about any of these documents at any time.

Patient Name (print): _____

Patient Signature: _____

Date: _____