STAR
Sexual Trauma & Recovery

CLIENT REGISTRATION

Date: _____

Last Name_____ First Name _____ M.I. _____

Street Address _____

City_____ State _____ Zip _____ SS# _____

Cell # (_____) _____Home # (_____) _____ Work # (_____) _____

E-mail_____ D.O.B ___/___/_____ (mm/ dd/ yyyy)

Permission to email invoices and other STAR correspondence? YES NO

Marital Status: Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed ☐ Other _____

Client's Employer _____Type of Business _____

Address_____ Occupation _____

How were you referred? _____Who is your first appointment with? _____

Overall health _____

List any medications _____

In case of an emergency, whom may we contact?

Name _____ Relationship _____ Phone _____

Information Pertaining to Spouse, Partner, Children or Other:

Spouse/ Partner Last Name _____First Name _____

Street Address _____ City _____

State _____ Zip _____ Telephone # (_____) _____

Date of Birth _____/_____/_____ (mm/ dd/ yy) Relationship to Client:Spouse ☐ Partner ☐ Other ☐

Employer's Name & Occupation _____

**Please note that we require a 48-hour notice for all cancellations. If you're unable to keep your appointment for a non-emergent reason, you will be charged for the cost of the session unless your time slot is filled by another client.*

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Informed Consent Form

Group and Individual Psychotherapy are widely accepted forms of psychological and psychiatric treatment. As with all forms of treatment, however, psychotherapy entails certain risks. This form is designed to tell you about some of the risks of limited confidentiality so that you can make an informed choice about whether you wish to enter therapy.

Risks include, but are not limited to the following:

1. The law may require the therapist to notify the authorities if you reveal that you are abusing children or if you express intent to harm yourself or to harm other people.

2. You are expected to hold confidential the information you hear and disclose in group and individual therapy. It is a forum that is intended to provide safety for those wishing to get well.

3. Remember, what you see and hear in group, remains in group.

4. If you violate the confidentiality rules of therapy, then the therapist may expel you from therapy.

In addition to the items noted above; be advised that your clinician delivers your care under the auspices of S.T.A.R. As such, clinical data can be shared internally between other attending S.T.A.R. clinicians. This is generally done during clinical staff meetings. It is done in an effort to offer you the most objective, effective care, especially if you are under couple's therapy at S.T.A.R.

I have read and fully understand the information provided above about the risks of group and individual psychotherapy. I have discussed these risks with the therapist and I have had the chance to ask all of the questions that I wished to ask about the matters listed above and about all other matters. The therapist has answered all of my questions in a way that satisfies me. I understand that I can leave therapy at any time. By signing this document I agree to accept the risks listed in this form and the risks explained to me by the therapist.

_____ _____

SIGNATURE OF CLIENT DATE

_____

PRINT NAME OF CLIENT

_____ _____

SIGNATURE OF THERAPIST DATE

Authorization Form

This form, when completed and signed by you, authorizes S.T.A.R. Inc, to release and/ or request protected health information from your clinical record to the person you designate.

Re: Client Name _____ Date of Birth _____ (mm/dd/yyyy)

I authorize S.T.A.R. Inc to release-Please check off section where appropriate:

☐ Psychotherapy Notes

☐ Psychological Exam and / or Testing Results

☐ Thank You for Referral Letter / Call

☐ Other (Please be specific and detailed about your request below)

☐ Telephone Contact/ Consultation

☐ Treatment Summary

☐ Medical Records

_____

This information should only be released TO OR FROM: (ONE PERSON/ ORGANIZATION PER FORM)

_____

Name of person, party, or agency

_____

Address City State/ Zip Code

_____

Telephone Number Fax Number Email Address

This authorization shall remain in effect until_____ or one year from the date signed or until_____.

You have the right to revoke this authorization, in writing, at any time by sending such written notification to S.T.A.R. However, your revocation will not be effective to the extent that S.T.A.R. has taken action in reliance on the authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.
I understand that S.T.A.R. and my psychotherapist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.
I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

_____ _____ _____

Signature of Self, Parent, or Guardian Printed Name Date signed

_____ _____ _____

Signature of Self, Parent, or Guardian Printed Name Date signed

*If the authorization is signed by a personal representative of the client, a description of such representative's authority to act for the client must be provided.

FINANCIAL TERMS

S.T.A.R. Inc. maintains a relatively straightforward financial relationship with its clients.

TYPES OF PAYMENTS WE ACCEPT:

Cash, check or credit card (VISA, DISCOVER, AMEX or MASTERCARD)

BILLING METHOD:

For group services we accept payment on a weekly basis for short term groups: Beginning/Recovery Start and on a semi-monthly basis for long term groups: Task/Partners/Advanced groups; when the service is rendered. When you enroll in one of our groups we will request a credit card number to help secure timely payment and to simplify matters.

Any accounts with unpaid balances greater than 30 days overdue are considered delinquent. Our office will notify you of this obligation and payment is expected upon receipt of this notification. Any accounts 90 days overdue will be placed with our collection agency, or, if the account is linked with an active STAR consumer, all treatment services will be discontinued until payment in full is made.

Like tuition, the client is expected to pay for all GROUP sessions, whether or not client is present. Extenuating circumstances will be considered on an individual basis. Understand that if you miss an individual therapy session or cancel with less than 48-hours' notice, you will be charged unless your time slot is filled with an appointment for another client. You are not expected to pay if you are seeking treatment or hospitalized.

INSURANCE:

Please note that STAR is not contracted with any insurance companies and is considered an out-of-network provider. STAR, as a courtesy to our clients, will provide receipts with data for the client to submit to insurance. It is not recommended that clients rely on any potential insurance reimbursement as a method to manage their balances with STAR. This practice runs the risk of falling past due with STAR. The client is responsible for servicing his/her account with star.

By signing this document, I acknowledge that I have read and agreed to accept all financial responsibilities.

_____ _____

Signature of client **Date**

Permission to include Diagnosis Codes on Invoices in order for client to bill insurance: ☐ YES ☐ NO
(NOTE: you must have out of network benefits - please check with your insurance carrier to find out more information)

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USE OF CASE MATERIALS FOR EDUCATIONAL/RESEARCH PURPOSES

Consent to allow data to be used for educational/research purposes: As part of an ongoing effort to insure quality treatment is offered to clients, this clinic participates in social science research and professional educational lectures for the purposes of improving the effectiveness of treatment. The risks associated with participating in research and allowing this clinic to use clinical data for educational lectures are no greater than the risks associated with counseling. Please note that if you choose not to participate in research or allow your clinical data to be used for professional lectures, you will not be penalized in any way nor will services be withheld from you.

Parental/guardian consent: as a parent and/or guardian, I understand I must consent to allow my child's assessment and treatment data to be used for educational/research purposes. My signature below indicates that I give consent for my child's data to be used for educational/research purposes.

If you have any concerns or questions about your role and/or rights in allowing the use of case materials for educational/research purposes and the risks associated with participating in research and/or allowing this clinic to use clinical data for educational lectures, please contact Cara Tripodi, LCSW, CSAT-S, Executive Director of STAR at 610-658-2737, or email: cara@starhealing.org.

Please read the following statement and indicate if you would be willing to participate:

"I give consent for clinical data collected as part of treatment to be used for the purpose of research with the understanding that **identifying information about me will be REMOVED from the data and my right to privacy and confidentiality will be protected at all times.** I understand that presentation of case histories and artwork may identify this clinic; however my name and other identifying information will be omitted or changed. I further understand that my treatment is not contingent on participating in research and that no services will be withheld if I choose not to participate. This consent is voluntary and I have been informed that I can withdraw this consent at any time."

☐ I give my consent ☐ I choose not to participate at this time

_____ _____

Client's signature and /or guardian authorization signature date

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW CLINICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

Your medical record compiled at S.T.A.R. (also referred to as "WE" below), contains personal information about you and your mental health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how S.T.A.R. may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act ("HIPAA"). It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations **We** may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.

Child Abuse or Neglect We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

Judicial and Administrative Proceedings We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

Deceased Patients We may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.

Medical Emergencies We may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

Family Involvement in Care We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

Health Oversight If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.

Law Enforcement We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

Specialized Government Functions We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

Public Health If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

Public Safety We may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Research PHI may only be disclosed after a special approval process or with your authorization.

Fundraising We may send you fundraising communications at one time or another. You have the right to opt out of such fundraising communications with each solicitation you receive.

Verbal Permission We may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and

disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to ***S.T.A.R.'s Business Office*** at: 919 Conestoga Rd. Suite #208 Bryn Mawr, PA 19010

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set". A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate reasonable requests. We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. We will not ask you for an explanation of why you are making the request.
- **Breach Notification.** If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with STAR at 919 Conestoga Rd. Suite #208 Bryn Mawr, PA 19010 or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. **We will not retaliate against you for filing a complaint.**

Receipt of Notice of STAR’s HIPAA Privacy Practices

I acknowledge that I have received S.T.A.R.’s Notice of HIPAA Privacy Practices.

____ _______________________
Client’s Signature Date

____
Print Name

<><><><><><><><><><><><><><><><><><><><><><><><><><><><><><><>

For Office Use Only
I attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices but acknowledgement could not be obtained because:

___ Individual refused to sign
___ Communication barriers prohibited obtaining the acknowledgement
___ An emergency situation prevented us from obtaining acknowledgement
___ Other (please specify)
____

____

CREDIT CARD on FILE AGREEMENT:

CREDIT CARD # _____ EXP. DATE (mm/yy)_____

VISA_☐____ MC__☐___ DISCOVER_☐___ AMERICAN EXPRESS __☐___

NAME ON CARD_____

ADDRESS _____

CITY _____ STATE_____ ZIP CODE _____

PHONE # _____

NAME OF CLIENT(S):_____

SIGNATURE_____ DATE _____

As an authorized signer on the credit card listed below, I give S.T.A.R. Sexual Trauma & Recovery Inc. permission to utilize the credit card for all charges related to and including services rendered at STAR Inc.