Susan A. Berger, LICSW, Ed.D.
Center for Loss & Healing
884 Old Connecticut Path
Framingham, MA 01702
(781) 962-6813
saberger@post.harvard.edu
www.drsusanberger.com

Dear Client,

I am grateful for your confidence in me to seek therapy for your behavioral health needs.

In order to work together most effectively, please provide me with the following information:

- **A copy of your insurance card (both sides). Please bring to your first session.**
- **Your copayment, by check or cash, at the beginning of the session. If you need a receipt, please inform me at the beginning of the session.**
- **A complete list of medications, for health and behavioral health treatment, to be filed in your record.**
- **A pain assessment, if appropriate, obtained prior to initiation of therapy.**
- **Contact information for your primary care physician (PCP), and other specialists that are relevant to your therapy.**

Please note that sessions are 45-50 minutes, reimbursed by your insurer.

If you request any additional services, such as letters, documentation, reports or consultations by email and/or phone, there will be additional charges based on my current hourly rate of $160/hour.

Thank you for your cooperation. I look forward to working with you.

Sincerely,

Dr. Susan Berger

Susan A. Berger, LICSW, Ed.D.
Center for Loss & Healing
Framingham, MA 01702
(781) 962-6813
saberger@post.harvard.edu
www.susanaberger.com

STATEMENT REGARDING PRIVATE HEALTH INFORMATION

Name: _____

It is the intent of this office to be in compliance with the Privacy Standards for Private Health Information (PHI) covered under Health Insurance Portability and Accountability Act (HIPAA).

- I understand that I have the right to request that certain information be excluded from my record unless the information is related to my diagnosis or is related to one of the exceptions listed on page 3 of the Therapist – Client Responsibilities.

- I understand that I have the right to amend information but not expunge ("erase") information from my record.

- I understand that I have the right to inspect and/or receive a copy of my Private Health Information (PHI) i.e. Record unless it is legally determined that it would adversely affect my well-being or I am a minor. My request must be fulfilled by this office within 60 days of my written request. There will be a charge for copies.

- As additional HIPAA regulations are mandated and clarified, this office will be altering its policies and procedures to be in compliance.

- If this office is found to be in violation of the Primary Standards put forth in HIPPA, I am urged to speak with my therapist and if not resolved, I have a right to file a formal compliant with the Office of Civil Liberties.

I have read and received a copy of the above Privacy Standards for Private Health Information covered under HIPPA.

Signed: _____ Date: _____

Susan A. Berger, LICSW, Ed.D.
Center for Loss & Healing
Framingham, MA 01702
(781) 962-6813 saberger@post.harvard.edu, www.drsusanberger.com

PATIENT INFORMATION SHEET

Name (last) _____ (first) _____ (initial) _____
(*as listed with your insurance)*
Phone (home/cell) _____ Work_____
Email address: _____ Referral source_____
Address:
street: _____
city: _____ _____
state: _____zip:_____

Patient's Date of Birth: _____ Subscriber's Date of Birth _____
Patient's Social Security #:_____ Subscriber's Employer_____
Patient's Occupation:_____ _____
Patient's Legal Status: (circle one) S • M • Sep • D • W Subscriber's Soc. Sec. #_____

Emergency Contact: _____Phone: _____
Relationship to Patient:____
Person To Receive Bill: _____
Phone:_____
Address
_____
(If different from above.)

Primary Care Physician (name, address, phone, email, if available):_____

HEALTH INSURANCE and Member ID # (check all that apply):

Blue Shield Type:_____ Subscriber Name: _____.
Tufts_____ Member ID #_____
Harvard Pilgrim_____ *(On insurance card)*
Neighborhood Health Plan_____
Medicare _____
Supplemental insurance e.g. Medex:# _____

I hereby authorize my insurance benefits to be paid directly to Susan A. Berger, LICSW, Ed.D. for the medical services rendered. I also authorize Dr. Berger to release any information necessary to process this claim.

Signature: _____ Date: _____
_

Susan A. Berger, LICSW, Ed.D.
Center for Loss & Healing
Framingham, MA 01702
(781) 962-6813
saberger@post.harvard.edu
www.drsusanberger.com

Cancellation Policy

When you schedule an appointment with me, you are "purchasing" that time. It is yours unless you cancel it PRIOR to 24 hours of your appointment time. The charge for a scheduled appointment not canceled prior to 24 hours is $100.00 unless it is an emergency.

"Emergencies" are considered events beyond your control such as snowstorms, car accidents, funerals, hospitalizations or illnesses which would keep you out of work.

This policy applies to an appointment you did not cancel because you have decided not to continue counseling, an appointment you "forget," or an appointment which conflicts with another one you have made. Charges for late cancellations or missed appointments are not billable to your insurance company.

If you cancel 2 consecutive appointments, before rescheduling, we will need to discuss your treatment goals and whether you are able to commit yourself to counseling at this time.

If you decide not to continue in counseling with me, please call my office and leave a message, especially if you have appointments scheduled.

It is my intention to provide you with the greatest possible selection of appointment times. If you have ever waited for a "cancellation appointment," you can appreciate someone who cancels in sufficient time for you to take that appointment. I hope this statement provides clarification to a system that has been working well for everyone. Thank you.

Signed: _____ *Date:* _____

Susan A. Berger, LICSW, Ed.D.
Center for Loss & Healing
Framingham, MA 01702
(781) 962-6813
saberger@post.harvard.edu
www.drsusanberger.com

CONSENT to RELEASE INFORMATION

Client's Name: _____ D.O.B._____

I hereby authorize Dr. Susan A. Berger, LICSW to release or request diagnostic and treatment information in my record from the following providers:

Psychiatrist/Therapist)_____

_____ _____

PCP _____

_____

(name, address, phone number and email address)

This information is needed for the purpose of coordination of care and on-going evaluation by telephone, facsimile, written documentation or meetings if indicated.

I understand that the practice abides by Federal Confidentiality Regulations (42 CFR, Part 2) published July 1, 1975, which protect the confidentiality of my records and that information contained in my record cannot be disclosed without consent unless otherwise provided for in the regulations.

I understand that this directive is subject to revocation at any time upon written request. Otherwise this consent will expire upon one year from date signed,

I herewith release and hold harmless, Dr. Susan A. Berger LICSW, from any liability for the release of any information provided in accordance with this directive.

_____ _____
Date Signed Witness

_____
Signature of Client or
Legal Guardian