Matthew Raso, Ph.D.
Licensed Psychologist

PATIENT REGISTRATION FORM

PATIENT INFORMATION—PLEASE PRINT

Today's Date: _____

Patient's Name: _____ Date of Birth: _____

Home Phone: _____ Mobile: _____ Work: _____

Email: _____

Address: _____
City: _____ State: _____ Zip Code: _____

Sex: ☐ M ☐ F ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed
Patient's Employer: _____ Employer Phone: _____
Employer Address: _____
Name of Person Responsible for Payment: _____
Emergency Contact: _____ Emergency Phone: _____

IF PATIENT IS A MINOR, COMPLETE THE FOLLOWING INFORMATION

Name of Person Completing Form: _____ ☐ Mother ☐ Father ☐ Legal Guardian

Mother/Guardian Name: _____
Home Phone: _____ Mobile: _____ Work: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Date of Birth: _____
Mother/Guardian Employer: _____ Occupation: _____
Employer Address: _____

Father/Guardian Name: _____
Home Phone: _____ Mobile: _____ Work: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Date of Birth: _____
Father/Guardian Employer: _____ Occupation: _____
Employer Address: _____

If Parents Single/Divorced, please indicate the following: ☐ Joint Legal Custody ☐ Custodial Parent _____

INSURANCE INFORMATION

Name of Insured (Primary Policy Holder): _____

Insurance Company Name: _____ Insured's Date of Birth: _____

Policy Number: _____ Effective Date of Coverage: _____

Group Number: _____

Relationship to Patient ☐ Self ☐ Spouse ☐ Parent ☐ Guardian ☐ Other_____

Matthew Raso, Ph.D.
Licensed Psychologist
12 Century Hill Drive, Suite 107
Latham, NY 12110
Phone: (518) 302-2812 Fax: (518) 309-6593

Consent for Child and Adolescent Therapy

Prior to beginning treatment, it is important for you to understand my approach to child therapy and agree to some rules about your child's confidentiality during the course of his/her treatment. The information herein is in addition to the information contained in the Outpatient Services Agreement. Under HIPAA and the APA Ethics Code, I am legally and ethically responsible to provide you with informed consent. As we go forward, I will try to remind you of important issues as they arise.

One risk of child therapy involves disagreement among parents and/or disagreement between parents and therapist regarding the best interests of the child. If such disagreements occur, I will strive to listen carefully so that I can understand your perspectives and fully explain my perspective. We can resolve such disagreements or we can agree to disagree, so long as this enables your child's therapeutic progress. Ultimately, you will decide whether therapy will continue. If either of you decides that therapy should end, I will honor that decision. However, I ask that you allow me the option of having a few closing sessions to appropriately end the treatment relationship.

Therapy is most effective when a trusting relationship exists between the psychologist and the patient. Privacy is especially important in securing and maintaining that trust. One goal of treatment is to promote a stronger and better relationship between children and their parents. However, it is often necessary for children to develop a "zone of privacy" whereby they feel free to discuss personal matters with greater freedom. This is particularly true for adolescents who are naturally developing a greater sense of independence and autonomy. By signing this agreement, you will be waiving your right of access to your child's treatment records. It is my policy to provide you with general information about treatment status. I will raise issues that may impact your child either inside or outside the home. If it is necessary to refer your child to another mental health professional with more specialized skills, I will share that information with you. I will not share with you what your child has disclosed to me without your child's consent. I will tell you if your child does not attend sessions. If your child is an adolescent, it is possible that he/she will reveal sensitive information regarding sexual contact, alcohol and drug use, or other potentially problematic behaviors. Sometimes these behaviors are within the range of normal adolescent experimentation, but at other times they may require parental intervention. We must carefully and directly discuss your feelings and opinions regarding acceptable behavior. If I ever believe that your child is at serious risk of harming him/herself or another, I will inform you.

Although my responsibility to your child may require my involvement in conflicts between the two of you, I need your agreement that my involvement will be strictly limited to that which will benefit your child. This means, among other things, that you will treat anything that is said in session with me as confidential. Neither of you will attempt to gain advantage in any legal proceeding between the two of you from my involvement with your child. In particular, I need your agreement that in any such proceedings, neither of you will ask me to testify in court, whether in person, or by affidavit. You also agree to instruct your attorneys not to subpoena me or to refer in any court filing to anything I have said or done. Note that such agreement may not prevent a judge from requiring my testimony, even though I will work to prevent such an event. If I am required to testify, I am ethically bound not to give my opinion about either parent's custody or visitation suitability. If the court appoints a custody evaluator, guardian ad litem, or parenting coordinator, I will provide information as needed (if appropriate releases are signed or a court order is provided), but I will not make any recommendation about the final decision. Furthermore, should I be involved in legal proceedings, it is agreed that my services will be paid for by the responsible party at my then current rates per hour of time.

_____ _____
Parent/Guardian Signature Date

_____ _____
Witness Signature Date

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Consent for Outpatient Services

Thank you for choosing to enter treatment and for entrusting your mental health care to me. This document contains important information about my professional services, confidentiality, and office/business policies. Please read it carefully and jot down any questions you might have so that we can discuss them. When you sign this document, it will represent an agreement between us.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and patient, and the particular problems you bring forward. However, general goals of therapy are often to help a client cope more effectively with problems in daily living, and to deal with inner conflicts that may disrupt one's ability to function effectively. There are many different methods I may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part, including working with your therapist to outline goals and assess your progress. An individual's progress in therapy is related to the work that is done collaboratively during your session, as well as that which is done between appointments.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who actively engage in the process. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress, although the experience is different for each participant. Our first session will involve an evaluation of your needs. By the end of that process, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, energy, and resources, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

MEETINGS

I normally conduct an initial diagnostic assessment, via clinical interview, that lasts 1 session. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. If psychotherapy is initiated, I usually schedule 45-minute sessions for family therapy and 53-60 minute sessions for individual therapy. Patients are generally seen on a bi-weekly basis, or more/less frequently as need dictates, and we agree.

CANCELLATION POLICY

Most days, there is a waiting list of patients who are eager to set up an appointment as soon as possible. As such, it is important to keep your appointment for the time it was scheduled. Appointments that are cancelled more than 24 hours in advance will *not* be charged a cancellation fee. Appointments that are cancelled less than 24 hours in advance will be charged a $75.00 late cancellation fee. Missed appointments will be charged at the private pay rate for an individual session ($150.00). Cancellations for a Monday appointment should be made no later than Friday. The fees will be waived if the appointment is able to be filled by another patient on short notice, or under extreme circumstances that we discuss.

PROFESSIONAL FEES

Out-of-network: If I do not accept your insurance, I can still provide my services as an out of network provider. In that case, my fee for the initial diagnostic evaluation is $175.00 and the fee for each psychotherapy session thereafter is $150.00.

Insurance: Co-pays for each psychotherapy session are required **at the time of service**. A $10.00 charge will be applied to all co-pays not paid at the time of service. I accept cash, credit/debit cards, and personal checks. Checks should be made payable to *Matthew Raso, Ph.D.* There will be a $30.00 fee for all returned checks. If a check is returned for insufficient funds, your account balance needs to be paid in full, including the returned check fee, in order to schedule future appointments. Moreover, future appointment copays must be paid in cash.

BILLING AND PAYMENTS

You will be expected to pay for each psychotherapy session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, legal costs will be included in the claim. In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of the services provided, and the amount due.

INSURANCE REIMBURSEMENT

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental (behavioral) health treatment. I will fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of my fees. It is very important that you find out exactly what mental (behavioral) health services your insurance policy covers.

You should carefully read the section in your insurance coverage booklet that describes mental (behavioral) health services. If you have questions about the coverage, call your plan administrator. I will provide you with whatever information I can based on my experience and will be happy to help you in understanding the information you receive from your insurance company. If it is necessary to clear confusion, I will be willing to call the company on your behalf.

You should also be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. Sometimes I have to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company's files and will probably be stored on a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit, if you request it. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above.

CONTACTING ME

I am often not immediately available by telephone. When I am unavailable, the office telephone is answered by voice mail. I will make every effort to return your call within 24 hours, with the exception of weekends and holidays.

EMERGENCIES

If you are unable to reach me and feel that you cannot wait for me to return your call due to a mental health emergency, you should call 9-1-1, or report to your nearest emergency room. If you reside in Albany County, you may also contact the Capital District Psychiatric Center—Mobile Crisis Unit at 518.447.9650. Additionally, the National Suicide Prevention Lifeline number is 1.800.273.8255. Should I be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

ELECTRONIC COMMUNICATIONS

Various types of electronic communications are common in our society, and many individuals believe this is the preferred method of communication with others, whether their relationships are social or professional. Many of these common modes of communication, however, put your privacy at risk and can be inconsistent with the law and with the standards of my profession. Consequently, this policy has been prepared to assure the security and confidentiality of your treatment and to assure that it is consistent with ethics and the law.

Email Communications

I use email communication only with your permission and only for administrative purposes unless we have made another arrangement. That means that email exchanges with my office should be limited to things like setting and changing appointments, billing matters and other related issues. Please do not email me about clinical matters because email is not a

secure way to contact me. If you need to discuss a clinical matter with me, please feel free to call me so we can discuss it on the phone, or wait so we can discuss it during your therapy session.

Text Messaging
Since traditional SMS text messaging is very unsecure, I utilize the SPRUCE healthcare app, which allows for HIPAA compliant communication. This requires that the patient also download the app. Messaging should be limited to things of a logistical nature, including setting up or changing an appointment, or billing questions. Clinical content should be saved for sessions. If you need to discuss a clinical matter prior to your scheduled session, you may also call me so we can discuss it on the phone.

Social Media
I do not communicate with, or contact, any of my patients through social media platforms like Twitter and Facebook. In addition, if I discover that I have accidentally established an online relationship with you, I will cancel that relationship. This is because these types of casual social contacts can create significant security risks for you. I believe that any communications with patients online have a high potential to compromise the professional relationship.

PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep treatment records. You are entitled to receive a copy of your records, or I can prepare a summary for you instead, unless I determine that to do so may cause emotional harm. Since these are professional records, they can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records, I recommend that you review them in my presence during a session so that we can discuss the contents.

CONFIDENTIALITY

In general, the privacy of all communications between a patient and a psychologist is protected by law, and I can only release information about our work to others with your written permission. However, there are a few exceptions. In some legal proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order my testimony if he/she determines that the issues demand it. However, I do not conduct child custody evaluations nor do I involve myself in related legal proceedings. Should I be contacted by your counsel or another for such a matter, you will be responsible for payment for the amount of time I am in correspondence with counsel, even if it is to explain that I do not become involved in child custody matters.

There are some situations in which I am legally obligated to act to protect others from harm, even if I have to reveal some information about a patient's treatment. For example, if I believe that a child is being abused, I must file a report with the appropriate state agency. If I believe that a patient is threatening serious bodily harm to another, I am required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient. If the patient threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection. If a similar situation occurs, I will make every effort to fully discuss it with you before taking any action. I may occasionally find it helpful to consult other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The consultant is also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have at our next meeting. Additionally, it is essential that you review the *Notice of Privacy Practices* for more detailed information regarding how your protected health information is handled.

STATEMENT OF RELEASE BY PATIENT TO INSURANCE COMPANY

I request that payment of authorized insurance benefits be made on my behalf (or, in the case of a minor, my child's behalf) to Matthew Raso, Ph.D for services furnished to me (or my child) by this practitioner. I authorize Matthew Raso, Ph.D to release medical and psychological information about me (or my child) to the applicable insurance company should this information be needed to determine these benefits. Please be advised that only the minimum necessary information will be disclosed to serve these administrative purposes.

- ✓ I understand that I am responsible for any unpaid balances not covered by my insurance, and that all co-pays and/or deductibles are due at the time of service.

Your right to privacy will be, at all times, protected. You have been provided access to a copy of the Notice of Privacy Practices, which outlines these rights. By signing this consent, you acknowledge that you have read the Notice of Privacy Practices or that it has been read to you, that you are at least 18 years old (or, if under 18, married or the parent of a child). that the above agreement is understood by you, and that you are signing this consent voluntarily.

_____ _____

Patient Signature (or Parent/Guardian if minor) Date

_____ _____

Witness Signature Date

Matthew Raso, Ph.D.
Licensed Psychologist
12 Century Hill Drive, Suite 107
Latham, NY 12110
Phone: (518) 302-2812 Fax: (518) 309-6593

Patient Request for Confidential Communications

- It is assumed that Dr. Matthew Raso, may contact you by telephone at your home and at your work, and in writing at your home, unless you inform him otherwise.

- Under HIPPA, you have the right to request that communications with you be confidential and by means acceptable to you. Dr. Matthew Raso will approve your request if it is feasible and mutually agreeable. Dr. Matthew Raso will honor your request, unless you specify you would like him to contact you if an emergency arises.

I wish to be contacted as follows:

☐ At my home telephone number _____

- ☐ You can leave messages with detailed information.
- ☐ Leave message with call-back number only.
- ☐ Call only at specified times of day _____

☐ At my mobile (cell) telephone number _____

- ☐ You can leave voice messages with detailed information.
- ☐ Leave voice message with call-back number only.
- ☐ Secure text messaging for the purpose of scheduling appointments (via Spruce Health)
- ☐ Call only at specified times of day _____

☐ At my work telephone number _____

- ☐ You can leave messages with detailed information.
- ☐ Leave messages with call-back number only.
- ☐ Call only at specified times of day _____

☐ In writing (including appointment reminders via email)

- ☐ My home address
- ☐ My work address
- ☐ My fax number(s) _____
- ☐ My email address _____

_____ _____
Patient Signature (or Parent/Guardian if minor) Date

_____ _____
Witness Signature Date

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12 Century Hill Drive., Suite 107, Latham, NY 12110
Phone: (518) 302-2812
Fax: (518) 309-6593
Email: matthew.raso.phd@gmail.com

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____(patient or parent/guardian if patient is a minor), authorize Matthew Raso, Ph.D. to release/obtain the private health information of _____(patient name) to/from:

Agency/Name: _____ Attn: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____ Fax: _____

Email: _____

DESCRIPTION OF INFORMATION TO BE USED OR DISCLOSED:

____Behavioral Health Records (e.g., diagnosis, treatment plan, treatment progress)

____Other (Specify:_____)

PLEASE MARK THE REASON THE INFORMATION IS TO BE USED OR DISCLOSED:

_____Coordination of Care _____School _____Legal/Court ____Personal/Family ____Insurance Benefits ____Research

This authorization shall remain in full effect until the end of our treatment relationship or it will expire 5 years from today, whichever comes first.

I understand that, except with respect to action already taken in reliance on this authorization, I may revoke this authorization in writing at any time by delivering or sending written notification to:

Matthew Raso, Ph.D., 12 Century Hill Drive., Suite 107, Latham, NY 12110 Email: matthew.raso.phd@gmail.com

I understand that Matthew Raso, Ph.D. may not condition treatment, payment, enrollment or eligibility for benefits on my signing this authorization, unless my treatment is related to research and the purpose of this authorization is related to the research project.

I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state privacy laws.

If this authorization is for the release of HIV-related information, the recipient of the information is prohibited from redisclosing any HIV-related information about you without your authorization unless permitted to do so by federal or state law.

I understand that I have the right to receive a copy of this authorization after I have signed it. I understand that a copy of this authorization will be maintained in my patient record.

I understand that I have the right to refuse to sign this authorization.

_____ _____
Patient Signature (or Parent/Guardian if minor) Date

_____ _____
Witness Signature Date