David Levingston, M.A., LMFT
Licensed Marriage and Family Therapist LMFT 100-0000054
229 Western Ave Brattleboro, VT 05301 415.717.0918 dlevingston@gmail.com

~ Signature Page For All Forms ~

Informed Consent, Patient Bill 'o Rights, HIPAA, CMS-1500

I/we have read, understand and agree to the information and policies described in the Informed Consent Form.

My signature acknowledges that I have been given the professional qualifications and experience of David Levingston, a listing of actions that constitute unprofessional conduct according to Vermont statutes, and the method for making a consumer inquiry or filing a complaint with the Office of Professional Regulation. This information was given to me no later than my third office visit.

I/we have read, understand and agree to the cancellation policy (does not apply to Medicaid).

I/we understand that if I/we miss a scheduled session and I/we don't provide at least 24 hours' notice, or if the absence is not due to an illness or emergency, I/we agree to pay **$50** (plus **$3 service fee** if paying by card).

I/we acknowledge receipt of the Patient Bill of Rights.

I/we acknowledge receipt of the HIPAA and Notice of Privacy Practices, which describes how medical information about you may be used and disclosed and how you can get access to this information.

I give permission to be contacted by David Levingston in writing if necessary, and/or to be sent a feedback survey sometime after therapy has ended.

For Managed Care Plans (the CMS-1500 form):

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.

I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

Person #1

_____
Print Name

_____
Signature

_____
Date

_____
Practitioner's Signature

Person #2

_____
Print Name

_____
Signature

_____
Date

_____
Fee Arrangement

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Welcome!

Introductory Questions

Best times to meet:

_ _ _ _ _ _ _ _ _ _ _ _

Today's Date:

- - - - - - - - - - - - - - - - Demographics

Person #1: Name: Gender: Age: Birthdate:

Marital Status: Single ? Married ? Other ? Employed ? Student ? F/T or P/T ?

Person #2: Name: Gender: Age: Birthdate:

Marital Status (Single ? Married ? Other ?) Employed ? Student ? F/T or P/T ?

Names of other individuals in the picture:

- - - - - - - - - - - - - - - -

Address:

Mailing Address (if different):

- - - - - - - - - - - - - - - -

Dx name(s): _

Phone - Person #1:

Home: OK to leave a message? Yes ☐ No ☐

Cell: OK to leave a message? Yes ☐ No ☐

Work: OK to leave a message? Yes ☐ No ☐

Phone - Person #2:

Home: OK to leave a message? Yes ☐ No ☐

Cell: OK to leave a message? Yes ☐ No ☐

Work: OK to leave a message? Yes ☐ No ☐

Counselor Use Only

DSM V Dx:

_ _ _ _ _ _ _ _ _ _ _ _

ICD-10 Dx - Insurance:

_ _ _ _ _ _ _ _ _ _ _ _

1st Session Date: _ _ _ _ _ _ _

Sig Page ☐ Date: _ _ _ _ _

PCP Consent ☐ Date: _ _ _ _ _

PCP Contact ☐ Date: _ _ _

Couples ☐ Transp ☐ Private

☐ Transp ☐ Private

Closure ☐ Date: _ _ _ _ _

- - - - - - - - - - - - - - - -

Email - Person #1:

Email - Person #2:

- - - - - - - - - - - - - - - -

Emergency Contact (Name, Address, Phone):

PCP (Doctor): Consent to contact? Yes ☐ No ☐

Employer/livelihood:

- - - - - - - - - - - - - - - - Insurance

Insurance Company and Policy Number:

Secondary/Add'l Insurance Coverage info:

Name(s): _____

- - - - - - - - - - - - - - - - - How did you get here and where do you want to go?

How did you hear about me? Who referred you?

Reason for coming to therapy:

How do you imagine things can be better for you?

How do you imagine we'll be using the time in our therapy sessions to help you?

- - - - - - - - - - - - - - - - - Primary relationships

Family constellation [small family tree of immediate relations, including pets you may have]:

For Family Therapy: Brief history of relationship: Years known, dated, living together, married, separated?

If you are a couple w/ children, do you get 1 hr/wk together, just the two of you? Yes ☐ No ☐
And how about 1 hr/wk alone to do your own thing, separate fr your partner? Yes ☐ No ☐

How much time do you spend talking w/your partner w/o your phone on and w/you? _____

- - - - - - - - - - - - - - - - - Physical health

Current physical health issues, conditions, limitations – anything affecting your capacity to function and enjoy life as fully as you would wish:

Current medications (name, dose, freq):

Allergies:

Diet:

Exercise:

Sleep: Any difficulty with: Falling asleep ☐ Staying asleep ☐ Getting up ☐

Name(s): _____

- - - - - - - - - - - - - - - - Mental health

Struggles with

Mood?
Anxiety?
Suicidal thoughts, plans, or actions (pls elaborate)?

Do you or are you aware if anyone you know has concerns about *your* use of alcohol or a drug? Yes ☐ No ☐
– Do you have concerns about *your partner's* use of alcohol or a drug? Yes ☐ No ☐

Past and present "compelling" relationships. Include type, amount, and frequency:

Alcohol:

Cannabis:

Heavier drugs (uppers / downers / all arounders):

Entheogens:

Food:

"Process Addictions" (e.g., work, gambling, shopping, internet, exercise, sex, caretaking):

Socially acceptable legal drugs. Include type, amount, and frequency:

Nicotine:

Caffeine:

Sugar:

- - - - - - - - - - - - - - - - Other considerations, past and present

Past issues (significant probs, accidents, hospitalizations, mental health incidents):

Other past and/or present experiences. specifically w/trauma or abuse – which could include physical, emotional, verbal, or sexual abuse. This can include past family issues including being around other family members who have issues with alcohol or other drug use:

Current existential / circumstantial limitations, challenges, struggles, stressors
– such as finances, work, living situation, legal issues, family, education:

Counseling in the past – and was it helpful or not:

Anything else you think would be helpful for me to know, including your strengths, interests. skills, and self-care modalities. Feel free to continue on the reverse side of the page:

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Informed Consent Form

Complimentary quote from a person I worked with: *"Thank you for making me feel human."*

Welcome. This psychotherapy disclosure form will answer many of your questions about my therapy services. Please feel free to ask questions if you need clarification or more info.

Non-Discrimination. My practice is open to all people, inclusive of all races, religions, spiritualities, ethnicities, cultures, gender identities and sexual orientations, and disabilities.

What is therapy about? I am open to how therapy can take different possible forms (including walking outside or making art). My orientation is called "eclectic", which means culling from different streams. My scope of practice focuses on helping people achieve healthier interpersonal relationships. In the end, I hope therapy serves your needs to connect better to yourself and others, to feel less isolated or down, and to connect to your own capacity to change your experience – whether it's your mood, or how you react to situations and people. Sometimes it is about coming to see reality as it is, and finding ways to be more at peace with it all. Sometimes what changes is our desire to change things.

My job is to help you be the person you want to be, and that may not always be easy. I want to respect you and your boundaries, so anything I may ask you to try is just an invitation. I never wish or expect you to do anything you don't ultimately wish to do. It is important that you take actions to take care of yourself through the process, and that can including declining invitations or even just pausing to gather yourself. Talking about things may bring up painful feelings. Perhaps you already know this on some level. I encourage you to try and be open and honest with yourself. You might face aspects of reality more directly and possible choices that you have been avoiding, and this might be upsetting or hard to be with. While the process is not meant to be re-traumatizing, sometimes people experience that or feel worse. Allow for times when things might not be so comfortable, and use your judgement for how much you want to lean into that edge of discomfort for the sake of whatever you value in the process. Also allow for some time. Sometimes change can happen quickly and sometimes change can take a while.

Our relationship. My style is interactive. I welcome discussion of any feelings you may have about our work together. Using the relationship itself can be an important part of the process in therapy.

Consider this: The word "therapist" derives from the Greek language. One meaning of the word *therapeuein* is "to attend."

My qualifications and experience. I began counseling in a professional context with the UCSF AIDS Health Project of San Francisco in 1999. In September 2001, I began the Integral Counseling Psychology program at California Institute of Integral Studies (CIIS) in San Francisco. I graduated with a Master's degree in December 2003, and I earned my Marriage and Family Therapist license for the State of California in January, 2007. This was granted reciprocity for the State of Vermont in October 2007. I continually augment my practice with continuing education and monthly peer consultations.

Professional regulations. My practice is governed by the Rules of the Board of Allied Mental Health Practitioners. It is unprofessional conduct to violate those rules. A copy of the rules and information on the process for making a consumer inquiry or filing a complaint with the Board may be found here: https://sos.vermont.gov/allied-mental-health/

A copy of the statutory definition of unprofessional conduct (3 V.S.A. ' 129a and 26 V.S.A. ' 4042 for licensed marriage and family therapists) can be found here:
https://legislature.vermont.gov/statutes/fullchapter/26/076

Confidentiality. With very few exceptions, the information discussed during your therapy session and all documentation (written or in any other medium) is kept private and confidential. When working with me, unless you communicate otherwise, you agree to allow consultation with other healthcare providers for the sake of your care, as permitted by HIPAA (see separate *HIPAA Notice of Privacy Practices* form). Some other very important exceptions to the rule of confidentiality are:

1. If there is a court order for the therapist to appear, or to produce the client's chart.
2. If you authorize your insurance plan to be used for services, some information may be shared for billing purposes and for evaluations to justify services and billing.
3. If the therapist learns that there exists a serious threat to any person.
4. If there is evidence of child or dependent adult or elder abuse.

Parents & Children: Children need to know that their parents have a *right* to know what goes on in therapy, but rather than reporting back *what* is said, I may discuss *how* things are going. I want both the child and the parent to know that it's important for the child to feel like what he or she is saying will be kept private. If you are a minor and your parents are covering the cost of sessions, you authorize discosures to parents necessary for purposes of payment.

Couples & Families: I encourage you to share any thoughts or feelings directly in our group sessions rather than privately with me.

Groups: As with individual therapy, I will hold confidential anything disclosed in groups. Group members are asked to agree to not share things with individuals outside the group.

Attendance. A regular weekly time together can make a difference in the kind of experience you have and progress you can make.

If you are running late, as long as you call to let me know, I'll wait and hold the time slot for you. Unless you call to let me know, I will wait for a 15 minute window after our appointed time, after which I will consider it a missed session and I may choose to leave the office to attend to other things.

If you happen to forget to appear for a scheduled session (and also forget to call in advance to let me know) more than one time, I may (at my discretion) provide you with a referral for other counseling opportunities that might be able to better accommodate your situation.

Time. Sessions are generally 50 minutes long (45 mins EAP; 53 mins managed care). Longer sessions can be scheduled if we agree that it will be helpful. I will let you know when there are 5 minutes left in the session. We need to end on time because of other scheduleded appointments.

Fees. Fees will be discussed and set by the end of the first session. My standard fee is $225/session. The initial assessment fee is $250. If you are using insurance, your financial responsibility will depend on your plan and my contracted rates with your company. If there are no specified contracted rates for your plan, the aforementioned rates apply. Please let me know if your current financial situation would make it difficult for you to afford my standard fee, so that we can talk about possible alternatives, including the option of a "sliding scale." Payment is to be made at the beginning of each session, and may be by cash or check. I do not bill. Fees will be reviewed yearly and may be raised approximately $10 per year. A 30 day notice will be given of any changes to fees.

For all uninsured and self-pay patients, a GFE (Good Faith Estimate) of expected charges is available and can be requested.

I generally do not write letters on behalf of clients for anything other than attesting to the fact of their attendance in outpatient therapy. That said, there may be a charge for time if you request work outside of the session, such as having letters written on behalf of clients to agencies, legal entities, or other practitioners. This time can not be billed to insurance. Time will be charged at a rate of $125/hr, rounded up to the nearest 15 minute increment.

Insurance. It is your responsibility to tell me (the provider) about your insurance and secondary insurance. If you wish to utilize health insurance to pay for services, please tell me the name of your plan, so that we can determine the extent to which our visits can be covered by your plan, if I am a contracted provider with your plan (in-network), and how billing will be done.

I will have you sign a *Self-Pay Agreement*, in cases where you attest that you:
a) do not have insurance coverage, or
b) have insurance coverage but chooses not to use it, and understand that in doing so your are waiving any right to reimbursement, or
c) have insurance coverage, but understand that your services are not covered by the plan.

The amount of reimbursement and the amount of any co-payments or deductible depends on the requirements of your specific insurance plan. You should be aware that insurance plans generally limit coverage to certain diagnosable psychological conditions and that this needs to be documented in some way. Although I am willing to help determine the terms of your policy, you should also be aware that you are ultimately responsible for verifying and understanding the terms and limits of your insurance coverage.

You are ultimately responsible for knowing and fulfilling whatever your financial obligations may be from participating in therapy services. If your responsibility is covered by a third party payer other than insurance (such as an HSA account), you agree to cover the cost, if payment is not received within a reasonable amount of time (60 days from date of receipt of claims by Insurance). If we had an understanding that your insurance plan would cover services, but then it turns out that your plan does not reimburse me for services rendered, either because your particular plan will not in fact cover my services, or because your plan is not active or has changed its terms, or for any other reason, it is your responsibility to cover any balance owed towards the cost of the session. Because any sessions in these cirmumstance are not conducted under the umbrella of the insurance plan, the cost of the session will be my standard fee of $100, and not the contracted rate that I have with the managed care organization.

If I am not a contracted provider and you would like to submit a bill to your insurance company to be reimbursed for our sessions, I will be happy, as a courtesy, to provide you with an insurance form at the end of each month. You are responsible for the payment for our services regardless of what the insurance company does or doesn't ultimately do. Although I may be willing to assist your efforts to seek insurance reimbursement, I am unable to guarantee whether your insurance will provide payment for the services provided to you.

Please know that for the sake of determining insurance coverage, the services rendered will be *Outpatient Mental Health*, and my license is an *LMFT (Licensed Marriage Family Therapist*). Even though my license has the word "marriage" in its title, the services are not to be considered "marriage counseling." Please know that most insurance will not cover marriage counseling but will cover outpatient psychotherapy.

Please know that when any agency (such as health insurance) is involved, your confidentiality will be affected. Some manged care plans may require submission of information about your therapy for review and authorization of services and justification for reimbursement.

Please discuss any questions or concerns that you may have about this with me.

Telemedicine/Telehealth policy. Telehealth is not appropriate for all client's situations. Therapist will determine this and discuss options with client. In situations where we decide to have a real-time interactive session when we are not in the same physical location, by connecting using some means (e.g., video, telephone, or texting) other than a live face-to-face meeting, your participation means you consent and authorize the use of telehealth as an acceptable medium for your treatment. When possible, we will use the Google Meet HIPAA-Compliant platform. No recordings will be made by either party. You understand that other platforms (include Skype, FaceTime, and telephone) may not be secure. You understand that technical difficulties may occur before or during the telehealth sessions and that your appointment may not be started or ended as intended. In the event that we are unable to establish a video connection, we will first quit and restart the application. If that does not remedy the connection, we agree to use our phones as a backup. If we get disconnected, I will wait up to 3 minutes for you to call me. If you don't, you are still responsible for covering the cost of the session. If your insurance only covers live interactive video and you are unable to connect due to technical issues on your end, and we are unable to find another time to meet during the same week, you will be responsible for covering the cost at my usual private pay rate. We will discuss an emergency protocal, including an emergency contact to reach if deemed necessary by the therapist.

Cancellation policy. I will be reserving the time and the room for you, so please give me as much notice as possible if you won't be able to make it for your appointed session. If you need to cancel, I require thay you do so by phone rather than by text or by email, because email is not reliable. Email also isn't encrypted and is vulnerable to intrusion. My voice mail is available 24 hours a day to receive messages. I do not always check email regularly; sometimes not for weeks at a time. Therefore, if you need to contact me, please call.

If you do not show up for your scheduled therapy appointment, and you have not notified me at least 24 hours in advance, and it is not a health emergency that you yourself are experiencing, you agree to pay $50 for the session (plus $3 service fee if paying by card), which is half of my customary fee, as your health plan does not cover payment for a missed appointment. Likewise, if I fail to appear or to give 24 hours notice of a cancellation, your next appointment is at no charge to you. Just as I will give you a 15-minute window to arrive, please allow me a 10-minute window to be ready for you, as sometimes I may run a wee bit behind.

Contact (including Email, Texts, Cell Phones, & Computers) and after hours emergencies. My usual business hours are weekdays between 9:00 AM and 6:00 PM. If I am unable to answer the phone, please leave me a message. I check my messages during business hours and I will return your call as soon as I can. I will usually return calls & emails within 1 business day. You are welcome to leave a voice mail at any time, but I may not be able to retrieve your message until my business hours.

I am not available after hours for emergencies. For after-hours emergencies or if you need immediate assistance, call the 24-hr local crisis team at 1-800-622-4235. If you are feeling very out of sorts and need a soft place to land, you can also contact your medical group or your primary care physician, or visit the emergency department of your local hospital, and they will help direct you. If you are feeling suicidal, please call 1-800-622-4235.

If using Texting or Email, you acknowledge the understanding that these are not necessarily secure and confidential mediums of communication. Before sending you any initial Emails, I will ask for your verbal permission to do so. If you communicate confidential or private information via unencrypted digital communication, texts or e-fax or via phone messages, I will assume that you have made an informed decision. If any misunderstandings or upsets come up for you, please call to give me a chance to correct the experience.

Regarding Emailings, except for matters of scheduling, please save other questions and interpersonal sharings for our scheduled sessions.

If there is an emergency or if you need to cancel a session on sudden notice and it is less than 24 hrs before the session, please call rather than email to assure that I will receive your message.

Outside contact. Respecting your preferences for privacy, we will discuss how we shall handle contact by phone and contact outside the therapy context, if we happen to run into each other in public.

Social Media. You are welcome to peruse my professional Facebook page: www.facebook.com/DavidLevingstonMFT. However, as an ethical guideline, I generally refrain from connecting with clients, both past and present, through Facebook, LinkedIn, Twitter, and other online sites of this nature.

Drug use. Please come to therapy sessions not under the influence of mind/mood-altering drugs (except for prescriptions), whatever that may mean for you. I see our work as about learning to be with reality as it is.

Notes. Sometimes I may take notes while we talk. It helps my work with you.

Exchanges and bartering. We will discuss the ethics of exchanges such as bartering of services or giving of gifts.

Touch. "*Talk* therapy," is different than hands-on body work, but can include directing one's awareness towards the body. While different cultures may include gestures of touch such as handshakes and hugs, I wish to respect and defer to your preferences. We will discuss the issue of contact and how we shall handle scenarios such as greetings and goodbyes.

Ending. Your participation in therapy is voluntary and you have the right to end therapy whenever you want. However, if you do decide to exercise this option, I encourage you to talk with me about the reason for your decision in a counseling session together. I ask that you allow for two final sessions for us to have an ending together, to review what we've done and to offer feedback to each other. Likewise, at my discretion, I reserve the right to end our therapy work together and provide you with some appropriate referrals, for reasons including, but not limited to, failure to participate in therapy, conflicts of interest, untimely payment of fees, or my belief that I may not be the best person for your needs.

Please sign the **Signature Page** and keep a copy for yourself. Should you have any questions at any time, please ask.

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Patient Bill of Rights

You have the right to:

Request and receive full information about the therapist's professional capabilities, including licensure, education, training, experience, professional association membership, specialization, and limitations.

Have written information about fees, method of payment, insurance reimbursement, number of sessions, substitutions (in cases of vacation and emergencies), and cancellation policies before beginning therapy.

Receive respectful treatment that will be helpful to you.

A safe environment, free from sexual, physical, and emotional abuse.

Ask questions about your therapy.

Refuse to answer any question or disclose any information you choose not to reveal.

Request that the therapist inform you of your progress.

Know the limits of confidentiality and the circumstances in which a therapist is legally required to disclose information to others.

Refuse a particular type of treatment or end treatment without obligation or harassment.

Refuse electronic recording (but you may request it if you wish).

Request and (in most cases) receive a summary of your file, including the diagnosis, your progress, and type of treatment

Report unethical and illegal behavior by a therapist.

Receive a second opinion at any time about your therapy or therapist's methods.

Request the transfer of a copy of your file to any therapist or agency you choose.

Source: California Department of Consumer Affairs

http://www.calpsychlink.org/resources/patientbillofrights.htm

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I am required by law to maintain the privacy and security of your protected health information ("PHI") and to provide you with this Notice of Privacy Practices ("Notice"). I must abide by the terms of this Notice, and I must notify you if a breach of your unsecured PHI occurs. I can change the terms of this Notice, and such changes will apply to all information I have about you. The new Notice will be available upon request, in my office, and on my website.

Except for the specific purposes set forth below, I will use and disclose your PHI only with your written authorization ("Authorization"). It is your right to revoke such Authorization at any time by giving me written notice of your revocation.

Uses (Inside Practice) and Disclosures (Outside Practice) Relating to Treatment, Payment, or Health Care Operations Do Not Require Your Written Consent. I can use and disclose your PHI without your Authorization for the following reasons:

1. **For your treatment**. I can use and disclose your PHI to treat you, which may include disclosing your PHI to another health care professional. For example, if you are being treated by a physician or a psychiatrist, I can disclose your PHI to him or her to help coordinate your care, although my preference is for you to give me an Authorization to do so.

2. **To obtain payment for your treatment**. I can use and disclose your PHI to bill and collect payment for the treatment and services provided by me to you. For example, I might send your PHI to your insurance company to get paid for the health care services that I have provided to you, although my preference is for you to give me an Authorization to do so.

3. **For health care operations**. I can use and disclose your PHI for purposes of conducting health care operations pertaining to my practice, including contacting you when necessary. For example, I may need to disclose your PHI to my attorney to obtain advice about complying with applicable laws.

Certain Uses and Disclosures Require Your Authorization.

1. **Psychotherapy Notes**. I do keep "psychotherapy notes" as that term is defined in 45 CFR § 164.501, and any use or disclosure of such notes requires your Authorization unless the use or disclosure is:

a. For my use in treating you.

b. For my use in training or supervising other mental health practitioners to help them improve their skills in group, joint, family, or individual counseling or therapy.

c. For my use in defending myself in legal proceedings instituted by you.

d. For use by the Secretary o fHealth and Human Services to investigate my compliance with HIPAA.

e. Required by law,and the use or disclosure is limited to the requirements of such law.

f. Required by law for certain health oversight activities pertaining to the originator of the psychotherapy notes.

g. Required by a coroner who is performing duties authorized by law.

h. Required to help avert a serious threat to the health and safety of others.

2. **Marketing Purposes**. As a psychotherapist, I will not use or disclose your PHI for marketing purposes**.**

3. Sale of PHI. As a psychotherapist, I will not sell your PHI in the regular course of my business.

Certain Uses and Disclosures Do Not Require Your Authorization. Subject to certain limitations in the law, I can use and disclose your PHI without your Authorization for the following reasons:

1. When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.

2. For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone's health or safety.

3. For health oversight activities ,including audits and investigations.

4. For judicial and administrative proceedings, including responding to a court or administrative order, although my preference is to obtain an Authorization from you before doing so.

5. For law enforcement purposes, including reporting crimes occurring on my premises.

6. To coroners or medical examiners, when such individuals are performing duties authorized by law.

7. For research purposes, including studying and comparing the mental health of patients who received one form of therapy versus those who received another form of therapy for the same condition.

8. Specialized government functions, including**,** ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counter-intelligence operations; or, helping to ensure the safety of those working within or housed in correctional institutions.

9. For workers' compensation purposes. Although my preference is to obtain an Authorization from you, I may provide your PHI in order to comply with workers' compensation laws.

10.Appointment reminders and health related benefits or services. I may use and disclose your PHI to contact you to remind you that you have an appointment with me. I may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that I offer.

Certain Uses and Disclosures Require You to Have the Opportunity to Object.

1. **Disclosures to family, friends, or others**. I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

YOUR RIGHTS YOUR REGARDING YOUR PHI

You have the following rights with respect to your PHI:

1. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask me not to use or disclose certain PHI for treatment, payment, or health care operations purposes. I am not required to agree to your request, and I may say "no" if I believe it would affect your health care.

2. The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full. You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-

pocket in full.

3. The Right to Choose How I Send PHI to You. You have the right to ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and I will agree to all reasonable requests.

4. The Right to See and Get Copies of Your PHI. Other than "psychotherapy notes," you have the right to get an electronic or paper copy of your medical record and other information that I have about you.

I will provide you with a copy of your record, or a summary of it, if you agree

to receive a summary, within 30 days of receiving your written request, and I may charge a reasonable, cost based fee for doing so.

5. The Right to Get a List of the Disclosures I Have Made. You have the right to request a list of instances in which I have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided me with an Authorization.

I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable cost based fee for each additional request.

6. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that I correct the existing information or add the missing information. I may say "no" to your request, but I will tell you why in writing within 60 days of receiving your request.

7. The Right to Get a Paper or Electronic Copy of this Notice.You have the right to get a paper copy of this Notice, and you have the right to get a copy of this notice by e-mail. And, even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy of it.

HOW TO COMPLAIN ABOUT MY PRIVACY PRACTICES

If you think I may have violated your privacy rights, you may file a complaint with me, as the Privacy Officer for my practice, and my address and phone number are:

David Levingston
229 Western Ave
Brattleboro, VT 05301
(415) 717-0918
_____.

You can also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by:

1. Sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201;
2. Calling1-877-696-6775; or,
3. Visiting www.hhs.gov/ocr/privacy/hipaa/complaints.

I will not retaliate against you if you file a complaint about my privacy practices.

EFFECTIVE DATE OF THIS NOTICE
This notice went into effect on September 20, 2013.

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

HEALTH INSURANCE CLAIM FORM

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? PLACE (State) YES NO

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

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: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY

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 TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a.

17b. NPI

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

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. b.

33. BILLING PROVIDER INFO & PH # ( )

a. b.

For Reference Only:
Front of a blank CMS-1500 (red ink) claim form.

For Reference:
Back of a blank CMS-1500 (red ink) claim form.

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION
(PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, pages 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed. Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0008. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, N2-14-26, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

For Reference:
Back of a blank CMS-1500 (red ink) claim form.