Ruth A. Lippin, LCSW
Cognitive Behavioral Therapist
285 West End Avenue, Suite 3Y-R1
New York, NY 10023
Email: Ruth@ruthlippin.com
Phone: 212.666.1062

AUTHORIZATION TO RECEIVE AND RELEASE INFORMATION

I, _____, authorize Ruth A. Lippin to discuss my information and treatment (includes any pertinent psychological and medical background information and current issues) with the following person:

NAME: _____
RELATIONSHIP: _____
ADDRESS: _____
PHONE NUMBER: _____

I understand this authorization will expire at termination of treatment or at any time prior upon written request. I hereby consent that this communication can take place through: (Please check all that apply.)

☐ Telephone ☐ Fax ☐ Email ☐ Mail

_____	_____	_____
Client Name	Client Signature	Date
_____	_____	_____
Parent's/Guardian's Name	Signature of Parent/Guardian	Date

Ruth A. Lippin, LCSW
Cognitive Behavioral Therapist
285 West End Avenue, Suite 3Y-R1
New York, NY 10023
Email: Ruth@ruthlippin.com
Phone: 212.666.1062

WELCOME

The following information is provided to assist you before you begin treatment. Please feel free to ask if you have additional questions.

Canceling appointments: 48 hours cancellation notice must be provided in order to avoid being charged for a session.

Payment: Payment by check or cash is due at the time of each visit.

Insurance: I do not participate in any insurance plans. Many insurance companies have out-of-network benefits that will reimburse you for all or part of my services.

Communicating out of session: A fee will be charged for telephone and email consultations that exceed 15 minutes per week.

Your signature indicates you understand the financial and cancelation policies of my practice.

_____	_____	_____
Client Name	Client Signature	Date
_____	_____	_____
Parent's/Guardian's Name	Signature of Parent/Guardian	Date

Ruth A. Lippin, LCSW
Cognitive Behavioral Therapist
285 West End Avenue, Suite 3Y-R1
New York, NY 10023
Email: Ruth@ruthlippin.com
Phone: 212.666.1062

PRIVACY NOTICE

This notice describes how protected health information (PHI) about you may be used and disclosed and how you can get access to this information. Please read this notice carefully.

I understand that your health information is private, and that I am required by law to maintain your privacy. In most situations, I can only release information about your treatment to others if you sign a written authorization form. However, there are some notable exceptions.

In the event that I am informed and determine there is a clear and present danger of either suicide or homicide perpetrated by a client, I am obligated to take reasonable measures to prevent harm. In the event I have reasonable cause to suspect that a minor patient is the victim of ongoing neglect, or suspected or confirmed child abuse, or is exhibiting suicidal and/or homicidal intent, their records may be given to the authorities without your permission.

There are other situations that require only that you provide written, advance consent. Your signature below provides consent for the following purposes:

- I may share your PHI with my staff for administrative purposes, such as scheduling, billing, and quality assurance. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice. Only necessary information is shared.
- I may disclose your PHI to other health care providers who provide you with health care services or are involved in your care.
- I may contact you to remind you of appointments.

The laws and standards regulating our profession require we keep treatment records. Please note the following:

- Any paperwork related to your therapy (e.g., treatment plans, insurance forms, etc.) is stored in a securely locked cabinet. Records are kept for five years from the last date of service, and then shredded and destroyed.
- You are entitled to see or receive a copy of your PHI, unless I believe such receipt would be detrimental to your well-being. Requests for records must be made in writing and a fee for copying may be charged. If I deny your request, I will tell you, in writing, the reason for denial.
- If you believe there is a mistake in your PHI or that a piece of information is missing, you have the right to request that I correct the existing information. You must provide the request and the reason for your request in writing.

Your signature below indicates you have read, understand and been given a copy of this PRIVACY NOTICE.

_____	_____	_____
Client Name	Client Signature	Date
_____	_____	_____

Parent's/Guardian's Name Signature of Parent/Guardian Date