Marie Donabella, Ph.D.
193 Waterman Street
Providence, RI 02906
401.829.7527

Client Information Form

Identification

Today's Date: _____

Name: _____
First Middle Last

Gender: Male Female Transgender

Address: _____
No. and Street City State Zip

Place of Employment:_____

Position/Title: _____

Phone #s: Home: _____ Work: _____ Other: _____

___ Please do **not** call me at home.
___ You may call me at home.
Can I leave a message for you if you are not there? Yes No (please circle)
Can I identify myself by name? Yes No

___ Please do **not** call me at work.
___ You may call me at work.
Can I leave a message for you if you are not there? Yes No (please circle)
Can I identify myself by name? Yes No

Relationship Status: (circle) Partnered Married Single Divorced Widowed

Name of Significant Other: _____

Address and Phone Number (if different from yours): _____

_____

Emergency contact_____ Phone: _____

Primary Care Physician: _____ Phone: _____

How did you hear about my services? _____

If you would like to receive my newsletter, please indicate your email address: _____

_____

Marie Donabella, Ph.D.
Client Information (con't)

Client Name:_____ Address:_____Phone#_____

City/State/Zip:_____

Insurance Information

Your Social Security Number: _____ Date of Birth: _____

Name of Primary Health Insurance: _____ Phone: _____

Address of Insurance Co: _____State: _____Zip: _____

Subscriber's name: _____ Subscriber DOB: _____Subscriber SSN#:_____

Relationship to client: _____self _____partner/spouse _____ parent ____ other

Policy Number: _____ Group Number: _____

Have you used this insurance for mental health reasons during the current year? Yes No

Name of Secondary Health Insurance: _____ Phone: _____

Address of Insurance Co: _____State: _____Zip: _____

Subscriber's name: _____ Subscriber DOB: _____Subscriber SSN#:_____

Relationship to client: _____self _____partner/spouse _____ parent ____ other

Policy Number: _____ Group Number: _____

I hereby assign to Marie Donabella, PhD all insurance payments for services rendered to my dependents or myself. I understand I am responsible for any amount not covered by insurance including annual deductibles. I authorize the release of any information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.
Date:_____ Signature:_____

MARIE DONABELLA, Ph.D.
NOTICE OF PRIVACY PRACTICES

I. 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.

II. I HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION ("PHI").

This notice explains how I use and disclose your protected health information ("PHI" for short). I am required by law to protect the privacy of PHI, and to provide you with this notice and follow the privacy practices described in it.

PHI includes information that I create or receive about your past, present, or future physical or mental health or condition, the provision of health care to you, or the payment for health care provided to you.

I may change the terms of this notice and my privacy practices at any time. Any change I make will apply to the PHI I already have as well as to any new PHI I create or receive. When I change my practices, I will promptly change this notice and post it in my office.

III. HOW I MAY USE AND DISCLOSE YOUR PHI.

I use and disclose PHI for many different reasons. Below, I describe the different reasons and give you some examples.

A. Use and Disclosure of PHI for Treatment, Payment, or Health Care Operations. I may use and disclose PHI for the following reasons:

1. For treatment. I may use and disclose PHI in order to provide therapy, counseling, treatment, and other services to you. For example, I may use and disclose PHI about you to consult with other professionals about your care. I will obtain your consent before disclosing your PHI for treatment purposes if state law requires me to do so.

2. For payment. I may use and disclose PHI in order to bill and collect payment for the treatment and services provided to you. For example, I may disclose PHI to your health plan to get paid for the health care services provided to you. I may also disclose PHI to billing companies and companies that process my health care insurance claims. I will obtain your consent before disclosing your PHI for payment purposes if state law requires me to do so.

3. For health care operations. I may use and disclose PHI in order to operate my practice For example, I may use PHI in order to evaluate the quality of services that you receive. I may also disclose PHI to my accountants, attorneys, and others in order to make sure I am complying with the laws that affect me. I will obtain your consent before disclosing your PHI for the purposes of my health care operations if state law requires me to do so.

B. Other Uses of PHI. I may also use and disclose your PHI for the following reasons:

1. Reports required by law. I may disclose PHI when legally required to do so. For example, I may use PHI to make mandatory reports to various government agencies about suspected abuse, mistreatment, neglect, or exploitation of vulnerable people such as children and the elderly.

2. Health oversight. I may disclose your PHI to certain government agencies authorized by law to license, audit, inspect, or investigate health and mental health care providers and the health care system.

3. To avoid harm. Consistent with state law, I may disclose PHI to the police or other appropriate persons, in order to avoid a serious threat to the health or safety of a client, another person, or the public.

4. Appointment reminders, treatment alternatives, and health-related benefits or services. I may use PHI to give you appointment reminders; or give you information about treatment choices or other health or mental health care services or benefits I offer.

5. Legal proceedings. I may disclose PHI pursuant to a valid court order, search warrant, and, under certain circumstances, in response to a subpoena or other discovery request.

6. As required by law. I will disclose PHI when required to do so by federal or state law.

C. When My Use or Disclosure of PHI Requires Your Prior Written Authorization. I must ask for your written authorization for any use or disclosure of PHI not described in sections III-A or III-B above. If you authorize me to use or disclose your PHI, you can later withdraw the authorization and stop any future use or disclosure of your PHI based on it. You can withdraw an authorization by sending written request to: Marie Donabella, Ph.D., 193 Waterman Street, Providence, RI 02906.

IV. YOUR RIGHTS REGARDING YOUR PHI.

A. Your Right to Request Limits on My Use and Disclosure of PHI. You may ask that I limit how I use and disclose your PHI. I will consider your request but am not legally required to agree to it. If I agree to your request, I will comply with your limits, except in emergency situations.

B. Your Right to Choose How I Send PHI to You. You may ask that I send information to you at a different address (for example, to your work address rather than your home address) or by different means (for example, by mail instead of telephone). I will agree to your request, as long as I can easily provide the information in the way you request.

C. Your Right to View and Get a Copy of Your PHI. You have the right to view or obtain a copy of your PHI. Your request must be in writing. However, there are some circumstances in which I may deny your request. If I deny your request, I will tell you, in writing, my reason(s) for the denial and explain what appeal rights, if any, you have.

If you request a copy of your PHI, I may charge a fee for it if permitted to do so by law. Instead of providing the PHI you requested, I may offer to give you a summary or explanation of the PHI, as long as you agree to it, and to the associated cost, in advance. To view or obtain a copy of your PHI please send your written request to: Marie Donabella, Ph.D. 193 Waterman Street, Providence, RI 02906.

D. Your Right to a List of the Disclosures of Your PHI that I Have Made. You have the right to an accounting of instances in which I disclosed your PHI to others. Some disclosures will not be listed, however. For example, the list will not include disclosures made for the purpose(s) of treatment, payment, or health care operations, or disclosures that you authorized or that were made directly to you.

I will report disclosures made within the six years prior to your request, unless you request a shorter timeframe. However, my obligation to account for disclosures begins with disclosures made after April 13, 2003.

If you ask for more than one accounting within a twelve-month period, I may charge you a fee for every accounting provided after the first one. For a list of disclosures you must submit a request to: Marie Donabella, Ph.D., 193 Waterman Street, Providence, RI 02906.

E. Your Right to Correct or Update Your PHI. If you feel that there is a mistake in your PHI, or that important information is missing, you may request a correction. Your request must be in writing and include the reason for the request. Your request must be made to: Marie Donabella, Ph.D., 193 Waterman Streeet, Providence, RI 02906.

I may deny your request for a variety of reasons. If I deny your request, I will inform you in writing of the reason(s) for the denial and explain your rights regarding responding to the denial.

If I agree to your request, I will change your PHI, inform you of the change, and tell others who need to know about the change to your PHI.

F. Your Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice, even if you agreed to receive it electronically. You may request a paper copy at any time.

V. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO FILE A COMPLAINT ABOUT MY PRIVACY PRACTICES.

If you have any questions about this notice, wish to exercise any of the rights explained in it or file a complaint about my privacy practices, feel that I may have violated your privacy rights, or disagree with a decision I made about your PHI, please contact: American Psychological Association, 750 First St., NE, Washington, DC 20002.

You also may send a written complaint to: Office for Civil Rights, U.S. Department of Health and Human Services, J. F. Kennedy Federal Building, Room 1875, Boston, MA 02203. I will not retaliate against you for filing a complaint.

VI. EFFECTIVE DATE OF THIS NOTICE.

This notice is effective as of April 14, 2003, and supersedes any and all prior versions of this notice.

Written Acknowledgement of Receipt of Privacy Practices

Client Name:_____
Date of Birth: _____
SSN:_____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Marie Donabella's ***Notice of Privacy Practices.*** I understand that if I have any questions regarding the ***Notice*** or my privacy rights, I can contact Marie Donabella, Ph.D.

_____
Signature of Client ***Date***

_____
Signature or Parent, Guardian or Personal Representative * ***Date***

_____

* *If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).*

❑ ***Client Refuses to Acknowledge Receipt****:*

_____
Witness of Refusal ***Date***

Marie Donabella, Ph.D.

193 Waterman Street
Providence, RI 02906
401.829.7527

PSYCHOTHERAPIST-CLIENT SERVICES AGREEMENT

Welcome to my practice. This document (the Agreement) contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a new federal law that provides new privacy protections and new patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this information at the end of this session. Although these documents are long and sometimes complex, it is very important that you read them carefully before our next session. We can discuss any questions you have about the procedures at that time. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance on it; if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

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 are experiencing. 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. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

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 many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, 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, money, and energy, 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 evaluation that will last from 2 to 4 sessions. 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 begun, I will usually schedule 50-minute sessions (one appointment hour of 50 minutes duration) at times we agree on. Some sessions may be longer or shorter. It is common for me to schedule meetings bi-weekly but more or less frequent sessions are possible. **Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 48 hours advance notice of cancellation [unless we both agree that you were unable to attend due to circumstances beyond your control]. It is important to note that insurance companies do not provide reimbursement for cancelled sessions.** If it is possible, I will try to find another time to reschedule the appointment.

PROFESSIONAL FEES

My hourly fee is $250.00 for the first session and $200.00 thereafter. In addition to weekly appointments, I charge this amount for other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than 10 minutes, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including

preparation and transportation costs, even if I am called to testify by another party. [Because of the difficulty of legal involvement, I charge $200.00 per hour for preparation and attendance at any legal proceeding.]

CONTACTING ME

Due to my work schedule, I am often not immediately available by telephone. While I am usually in my office on Tuesdays and Thursdays I probably will not answer the phone when I am with a patient. When I am unavailable, my telephone is answered by an answering machine that I monitor frequently. I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available. If you are unable to reach me and feel that you can't wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist or mental health professional on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communication between a patient and a psychologist. In most situations, I can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. Your signature on this Agreement provides consent for those activities, as follows:

- I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The other professionals are 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. I will note all consultations in your Clinical Record.
- You should be aware that I practice with other mental health professionals and that I employ a billing service. In most cases, I need to share protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing and quality assurance. All of the mental health professionals are bound by the same rules of confidentiality. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.
- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.

There are some situations where I am permitted or required to disclose information without either consent or Authorization:

- If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the psychologist-patient privilege law. I cannot provide any information without your (or your legal representative's) written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.
- If a government agency is requesting the information for health oversight activities, I may be required to provide it for them.
- If a patient files a complaint or lawsuit against me, I may disclose relevant information in order to defend myself.
- If a patient files a worker's compensation claim, I must, upon appropriate request, provide appropriate information, including a copy of the patient's record, to the patient's employer, the insurer or the Department of Worker's Compensation.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm and I may have to reveal some information about a patient's treatment. These situations are unusual in my practice.

- If I have reasonable cause to believe that a child under age 18 is suffering physical or emotional injury resulting from abuse inflicted upon him/her which causes harm or substantial risk of harm to the child's health or welfare (including sexual abuse), or from neglect (including malnutrition), the law requires that I file a report with the Department of Social Services. Once such a report is filed, I may be required to provide additional information.
- If I have reason to believe an elderly or handicapped individual is suffering from abuse, the law requires that I report to the Department of Elder Affairs. Once such a report is filed, I may be required to provide additional information.
- If a patient communicates an immediate threat of serious physical harm to an identifiable victim or if a patient has a history of violence and the apparent intent and ability to carry out the threat, I may be required to take protective actions. These actions may include notifying the potential victim, contacting the police, and/or seeking hospitalization for the patient.
- If a 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 such a situation arises, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary. 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 now or in the future. The laws governing confidentiality can be quite complex, and I am not an attorney. In situations where specific advice is required, formal legal advice may be needed.

PROFESSIONAL RECORDS

You should be aware that, pursuant to HIPAA, I keep Protected Health Information about you in two sets of professional records. One set constitutes your Clinical Record. It includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts on your life, your diagnosis, the goals that we set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that I receive from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier. You may examine and/or receive a copy of your Clinical Record if you request it in writing unless I believe that access would endanger you. In those situations, you have a right to a summary and to have your record sent to another mental health provider or your attorney. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them in my presence, or have them forwarded to another mental health professional so you can discuss the contents. If I refuse your request for access to your records, you have a right of review, which I will discuss with you upon your request

In addition, I also keep a set of Psychotherapy Notes. These Notes are for my own use and are designed to assist me in providing you with the best treatment. While the contents of Psychotherapy Notes vary from client to client, they can include the contents of our conversations, my analysis of those conversations, and how they impact on your therapy. They also contain particularly sensitive information that you may reveal to me that is not required to be included in your Clinical record. These Psychotherapy Notes are kept separate from your Clinical Record. While insurance companies can request and receive a copy of your Clinical Record, they cannot receive a copy of your Psychotherapy Notes without your signed, written Authorization. Insurance companies cannot require your Authorization as a condition of coverage nor penalize you in any way for your refusal. You may examine and/or receive a copy of your Psychotherapy Notes unless I determine that it would adversely affect your well-being, in which case you have a right to a summary and to have your record sent to another mental health provider or your attorney.

PATIENT RIGHTS

HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and my privacy policies and procedures. I am happy to discuss any of these rights with you.

MINORS & PARENTS

Patients under 18 years of age who are not emancipated and their parents should be aware that the law allows parents to examine their child's treatment records, unless I believe this review would be harmful to the patient and his/her treatment. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is sometimes my policy to request an agreement from parents that they consent to give up their access to their child's records. If they agree, during treatment, I will provide them only with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. I will also provide parents with a summary of their child's treatment when it is complete. Any other communication will require the child's Authorization, unless I feel that the child is in danger or is a danger to someone else, in which case, I will notify the parents of my concern. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless we agree otherwise. Payment schedules for other professional services will be agreed to when they are requested. In circumstances of unusual financial hardship, I may be willing to negotiate a fee adjustment or payment installment plan.

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 which will require me to disclose otherwise confidential information. In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. If such legal action is necessary, its costs will be included in the claim, along with late fees and interest.

INSURANCE

If you choose to have your insurance company billed or ask your insurance company for reimbursement of your payments you should remember several things:

1.) It is very important that you find out exactly what mental health services your insurance policy covers. It will usually provide some coverage for mental health treatment. If you request, I will give you a receipt or record of your payments.
2.) You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Of course, 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.
3.) Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. “Managed Health Care” plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. I will generally not complete Managed Care Authorization Forms for the reasons cited above. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person’s usual level of functioning. Assuming the insurance company agrees to pay for your expenses, it may be necessary for you to seek approval for more therapy after a certain number of sessions. While much can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end.
4.) When I bill an insurance company directly, you should also be aware that your contract with your health insurance company requires that I provide it with information relevant to the services that I provide to you. I am required to provide a clinical diagnosis. Sometimes I am required to provide additional clinical information such as treatment plans or summaries, or copies of your entire clinical record. In such situations, I will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in 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.

Marie Donabella, Ph.D.
193 Waterman Street
Providence, RI 02906
401.829.7527

Notice to Clients

Due to increasing operating costs, I must enforce my cancellation/no show policy as stated in the signed client-therapist services agreement. Thus, as a reminder, once an appointment hour is scheduled, unless it is an emergency or illness, **you will be expected to pay for the session unless you provide 48 hours advance notice of cancellation**. This is standard policy for most practitioners. Some people may find this policy harsh, but it is important to note that insurance companies do not provide reimbursement for cancelled sessions, and it is particularly difficult to fill a time slot in less than 48 hours. Missed session fees must be paid in full before a follow-up appointment will be scheduled. Whether services are covered or not by your insurance, you must remember that you are ultimately responsible for payment for services. I realize that temporary financial problems may at times affect timely payment of your account. If this should occur, I encourage you to contact me promptly for assistance in the management of your account. If your account should go unpaid and be without a payment arrangement, you will be subject to referral to a collection agency and/or legal action, as well as an additional administrative filing fee of $50.00 per incident.

Also please note that co-payments, (determined by your insurance company), **are due in full at the time services are rendered**. Methods of payment may include cash, check (made out to Marie Donabella), VISA, Mastercard, American Express, and Discover Card.

Thank you for your understanding.

Marie Donabella, Ph.D.

PSYCHOTHERAPIST-CLIENT SERVICES AGREEMENT

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT (*PSYCHOTHERAPIST-CLIENT SERVICES AGREEMENT*) AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE. BY SIGNING THIS AGREEMENT, YOU AGREE THAT I CAN PROVIDE REQUESTED INFORMATION TO YOUR INSURANCE CARRIER.

DR. DONABELLA PROVIDES PSYCHOLOGICAL SERVICES AS AN INDIVIDUAL PRACTITIONER. SHE IS NOT LEGALLY ASSOCIATED WITH ANY OTHER PROVIDER OF MENTAL HEALTH OR OTHER SERVICES RENTING AT 193 WATERMAN STREET, PROVIDENCE.

I (we) the undersigned agree to allow Dr. Donabella to provide evaluation, therapy, consultation or other psychological services to me (us).

_____ _____
Print Name Date

_____
Signature

_____ _____
Print Name Date

_____
Signature

Providence, RI 02906
(401) 829-7527

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Client:_____ Date of Birth:_____

I hereby authorize Marie Donabella, Ph.D. to release/obtain information:

Regarding: *Presence in treatment, progress in treatment, diagnosis, labs,*

_____

For the purpose of: *Facilitating treatment*,_____

_____

To/From:_____

_____

_____ Phone:_____ Fax:_____

I understand that the information in the health record may relate to treatment for alcohol or drug abuse and/or the results of diagnostic tests used to determine if the individual is infected by the human immunodeficiency virus (HIV). Unless I have indicated otherwise above, I specifically authorize the release of this information.

I understand that I have the right to revoke (cancel) this authorization at any time. I understand that to revoke this authorization, I must do so in writing and send my written revocation (cancellation) to Marie Donabella, Ph.D., at the above noted address. I understand that the revocation will not be effective until it is received, and it will not apply to information that has already been released in response to this authorization. I also understand that a revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Unless earlier revoked in writing, this authorization will expire 12 months after the date it was signed.

I understand that signing this authorization is voluntary and that Marie Donabella, Ph.D., will, if legally required, provide treatment and pursue payment for services regardless of whether I sign this authorization. If, however, my treatment is related to a research study, or solely for the purpose of providing information about my health or medical condition to someone else, Marie Donabella, Ph.D., may require that I sign this authorization before providing treatment to me.

I understand that if I authorize Marie Donabella, Ph.D., to disclose information, the recipient of the information might disclose it to others, and that any information disclosed by Marie Donabella, Ph.D., may no longer be protected by the federal rule on the privacy of medical records.

_____ _____
Signature of Client/Guardian Date

_____ _____
Witness Date

_____
Signature of Client Under 18