



PATIENT REGISTRATION

Should we thank any individual for referring you to Rose Hill Psychological Services, PC?		Date 11/2/2020	
Full Name Ryan Cox		DOB 12/31/1997	Age 22 <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female
Address 638 Wilson Ave			
City Brooklyn	State NY	Zip 11207	
Home Telephone <input type="checkbox"/> Primary Contact	Work Telephone <input type="checkbox"/> Primary Contact	Mobile <input checked="" type="checkbox"/> Primary Contact	7726782319
May we leave a voicemail? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		What is the best time to call? Morning / Evening	
Social Security Number 592730364		Email Address rycox@umich.edu	
Emergency Contact Name Joyce Cox		Relationship Mother	Emergency Contact Number 5613082363

INSURANCE CARD

FRONT of Insurance Card	BACK of Insurance Card
ADDITIONAL INSURANCE INFORMATION	

Are you the Primary Insured? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no please complete the following	Primary Insured's Name
Primary Insured's Date of Birth	Relationship: <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other

CREDIT CARD INFORMATION

Credit Card Type: <input type="checkbox"/> MasterCard <input checked="" type="checkbox"/> Visa <input type="checkbox"/> Discover <input type="checkbox"/> American Express		DocuSigned by 11/2/2020
Name, As it appears on statement Ryan Cox		Credit Card Number 4400662764740770
Expiration Date 0226	Security Code 760	Billing Zip Code 24121

CREDIT CARD AUTHORIZATION

I, Ryan Cox, authorize Rose Hill Psychological Service, PC to charge my credit card for agreed upon service(s) and/or cancelation fee(s). I understand that my information will be saved to file for future transactions on my account.

Signature 3D924CA26B734B0...	DocuSigned by: Date 11/2/2020
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**ACKNOWLEDGMENT OF RECEIPT
NOTICE OF PRIVACY PRACTICES**

By signing and dating this form, I acknowledge that I have received a copy Rose Hill Psychological Services, PC Notice of Privacy Practices.

Patient's Name (<i>Please print</i>) Ryan Cox	Last four digits of your Social Security 0364
Patient's Signature DocuSigned by:  3D924CA26B734B0...	Date 11/2/2020

If executed by a patient's personal representative, please complete the information in the space below:

Personal Representative's Name (<i>Please print</i>)	Relationship
Personal Representative's Signature	Date

If executed by a patient's legal guardian, please complete the information in the space below:

Legal Guardian's Name (<i>Please print</i>)	Relationship
Legal Guardian's Signature	Date



AUTHORIZATION & CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

PSYCHOTHERAPY

INITIAL ANNUAL UPDATE

TREATMENT AUTHORIZATION: I (print name) Ryan Cox consent to the use or disclosure of my protected health information by Rose Hill Psychological Services, PC, for the purpose of diagnosing or providing treatment to me or my minor child, obtaining payment for my health care bills or to conduct necessary health care operations at Rose Hill Psychological Services, PC. I further authorize Psychotherapy treatment to myself or my minor child by the therapists and staff at Rose Hill Psychological Services, PC.

INFORMED CONSENT: The term "informed consent" means that the potential risks, benefits, and alternatives of psychotherapy treatment have been explained to you.

The therapist provides a wide range of services and I understand that I will receive information at the initial visit concerning the treatment and options available for my condition.

Psychotherapy, sometimes called talk therapy, is a treatment that involves an interactive relationship between a treating provider and a patient. Psychotherapy can be used to treat a broad spectrum of mental health disorders, emotional and relationship difficulties. Psychotherapy has both benefits and risks. In order for therapy to be most successful, I may need to discuss uncomfortable feelings, such as sadness, guilt, anger, frustration, loneliness or helplessness. Psychotherapy often leads to improved relationships, solutions to specific problems and significant reductions in emotional and mental distress.

REFERRAL AUTHORIZATION: Your insurance carrier may require a referral from your primary care physician for our services. Please be aware that it is your responsibility to obtain all necessary referrals prior to therapy. If your insurance carrier required an authorization for service, no service will be rendered until the authorization is obtained. Further, we may contact your doctor for a referral and/or treatment orders.

MEDICAL DOCTOR: Rose Hill Psychological Services, PC, believes your physician is a vital part of your health care team. Many insurance carriers require we receive authorization and or referrals from your physician, listed below. Upon request your physician will also be updated with any relevant evaluation and or progress reports.

NAME: _____ SPECIALTY: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

TELEPHONE: _____ FAX: _____

CANCELLATION AND/OR NO-SHOW POLICY: Rose Hill Psychological Services, PC urges you to keep every appointment, as consistent treatment will expedite your recovery. In the event you need to cancel an appointment, we require at least 72 hours notice, excluding Saturday and Sunday. Patients who cancel without proper notice or fail to show for a scheduled appointment will be subject to a \$125.00 charge for each occurrence. Session length will be reduced as a result of lateness.

ASSIGNMENT OF BENEFITS: As I authorize direct remittance of payment of all insurance benefits, including Medicare, if I am a Medicare beneficiary, to Rose Hill Psychological Services, PC for all covered medical services and supplies provided to me during all courses of treatment and care provided by Rose Hill Psychological Services, PC, and/or its affiliated entities or otherwise at its direction. I understand and agree this Assignment of Benefits will constitute a continuing authorization, maintained on file with Rose Hill Psychological Services, PC, which will authorize and allow for direct payment to Rose Hill Psychological Services, PC of all applicable and eligible insurance benefits for all subsequent and continuing treatment, services, supplies and/or care provided to me by Rose Hill Psychological Services, PC. If insurance payments are made directly to me, I will endorse such payments to Rose Hill Psychological Services, PC, within five (5) days of receipt of such payment.

Initials: RC

Patient Name: Ryan Cox

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FINANCIAL/INSURANCE RESPONSIBILITIES: I understand and agree to the following policies regarding financial and insurance responsibilities. Payment is required at each visit. This responsibility includes co-insurance, deductible amounts, non-covered and excluded items not paid for by my insurance carrier or other party responsible for coverage of my medical expenses. I understand that insurance billing is a service provided as a courtesy and that I am at all times financially responsible to Rose Hill Psychological Services, PC, and/or its affiliated entities for any charges not covered by healthcare benefits. It is my responsibility to notify Rose Hill Psychological Services, PC, of any changes in my healthcare coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by Rose Hill Psychological Services, PC, and/or my healthcare insurer if the submitted claims or any part thereof are denied for payment. I understand that by signing this authorization that I am accepting financial responsibility as explained above for all payment for medical services.

I understand my medical insurance is a contract between my insurance company and I. Rose Hill Psychological Services, PC, is **NOT** a party to that contract and will not be obligated to take action on my behalf against an insurance company for collecting or negotiating my insurance claim. I agree to be responsible for costs and expenses, including court costs, attorney fees and interest, should it be necessary for Rose Hill Psychological Services, PC, to take action to secure payment of an outstanding balance owed. Payments received will be posted to the oldest outstanding balance on your account first.

FURTHER NOTICES AS TO POLICIES REGARDING MEDICARE: Michael Civin, PhD is a participating provider of Medicare; as such we will handle all billing to Medicare and any secondary insurance. Medicare requires you to satisfy a yearly deductible before they will begin paying benefits. Medicare will deduct the deductible amount from the first claim they receive each calendar year. Unless you have satisfied your annual deductible with another Medicare provider's office you are responsible to pay your deductible. After your deductible is satisfied Medicare will reimburse us 80% of their standard fee for approved services provided. Therefore your payment responsibility is 20% of the standard Medicare fee for those services. Medicare has an annual financial allowance for Out Patient Therapy Services. Unless you have additional insurance coverage you will be responsible for payment of any treatments in excess of the Medicare allowance.

I understand that, in certain circumstances, Medicare may find that services are not "reasonable and/or medically necessary" for the illness, injury or condition for which I am seeking treatment. I understand that Medicare bases this ruling on the diagnosis provided by my healthcare provider and their standards for that diagnosis. I understand, in this case, I will be responsible for any and all charged incurred.

NO GUARANTEES: I am aware that no practice of medicine is an exact science and acknowledges that there are and can be no guarantees as to accuracy or outcomes of any diagnosis or treatments that I receive at Rose Hill Psychological Services, PC. I understand that Rose Hill Psychological Services, PC, shall have the right at any time to refuse to provide medical care or treatment to me.

REVOCATION OF AUTHORIZATION: I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to Rose Hill Psychological Services, PC. Such revocation will not affect my financial responsibility to pay for services rendered by Rose Hill Psychological Services, PC. I understand that this revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

PATIENT ACKNOWLEDGMENT: I certify that the information I provide to my practitioners and my insurance company is correct. I certify that I am here to receive medical care and for no other purpose. I do not represent any third party. By signing and dating this form, I acknowledge that I have received a copy of this Authorization and Consent.

DocuSigned by:

PATIENT SIGNATURE:


3D924CA26B734B0...DATE: 11/2/2020

WITNESS SIGNATURE:

DATE:



NOTICE OF PRIVACY PRACTICES

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

IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE FEEL FREE TO SPEAK TO YOUR DOCTOR, HIS/HER DESIGNEE OR THE HIPAA PRIVACY OFFICER.

Rose Hill Psychological Services, PC is committed to maintaining and protecting the confidentiality of your personal information. This Notice of Privacy Practices is being provided to you as a requirement of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). It will inform you about the ways in which we may use and disclose your health information, and the safeguards we have put into place to protect it. It also describes your rights and certain obligations we have regarding the use and disclosure of your health information.

OUR DUTIES TO YOU REGARDING YOUR PROTECTED HEALTH INFORMATION

“Protected Health Information” is individually identifiable health information expressed in the form of oral, written or electronic communications. This information includes demographic information such as your age, address, email address, and other information that relates to your past, present or future health condition and related healthcare services. Rose Hill Psychological Services, PC is required by law to:

- Make sure your health information is kept private.
- Give you this notice of our legal duties and privacy practices related to the use and disclosure of your protected health information.
- Follow the terms of the notice currently in effect.
- Communicate any changes in this notice to you.

GOVERNMENTAL PRIVACY LAWS AND REGULATIONS

There are several other federal, state and city privacy laws that provide stronger restrictions about the use and disclosure of health information. The stricter laws have been taken into consideration in developing our policies and this notice of how we will use and disclose your protected health information.

HOW WE USE AND DISCLOSE YOUR HEALTH INFORMATION

The following categories describe different ways that we use and disclose your health information. We will not use your confidential information or disclose it to others without your authorization, except for the following purposes:

Treatment. We may use and/or disclose your confidential health information to provide you with treatment and/or services. This includes your doctor's recommendation(s), and those of other professionals/paraprofessionals including clerical, coordination and management staff.

Payment. Your protected health information will be used, as needed, to bill and collect payment for treatment and services provided to you. We may share information about a treatment and/or service you may receive to your health insurer to receive approval for payment.

Health Care Operations. We may use and disclose health information about you for regular health care operations. The medical staff in this practice will use your health information to assess the care you received and the outcome of your case compared to others like it. Your information may be reviewed for risk management or quality assessment/improvement purposes in our efforts to continually improve the quality and effectiveness of the care and services we provide.

We will share your protected health information with third-party “business associates” who perform various activities for the practice. The business associates will also be required to protect your health information.

We may remove information that identifies you from this set of health information so others may use it to study health care and health care delivery without learning your identity.

Appointment Reminders. We may use and disclose health information to contact you as a reminder that you have an appointment for treatment or care in our Practice. These reminders will not identify the purpose of your visit.

Required by Law. We will disclose health information about you when required to do so by federal, state or local laws.

Public Health Activities. We may disclose your confidential health information for the following public health activities and purposes:

- To report health information to public health authorities that are authorized by law to receive such information for the purpose of preventing or controlling disease, injury or disability;
- To report child abuse or neglect to a government authority that is authorized by law to receive such reports;
- To report information about a product or activity that is regulated by the US Food and Drug Administration (FDA) to a person responsible for the quality, safety or effectiveness of the product or activity;
- To conduct post-marketing surveillance, as required; and
- To alert a person who may have been exposed to a communicable disease, if we are authorized by law to give this notice.

Legal Proceedings. We may release protected health information about you in response to a court or administrative order if you are involved in a lawsuit or dispute. We may also disclose health information about you in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request.

Law Enforcement. We may release health information if asked to do so by law enforcement officials:

- In response to a court order, subpoena, warrant, summons or similar process.
- To identify or locate a suspect, fugitive, material witness or missing person.
- About the victim of a crime if, under certain circumstances, we are unable to obtain the person's agreement.
- About the death we believe may be the result of criminal conduct.
- About criminal conduct at the Practice.
- In emergency circumstances to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Research. Under certain circumstances, we may use and disclose your confidential information for research purposes without an authorization. An authorization would not be necessary if your identifying information was removed.

Workers' Compensation. We may release your health information to comply with Workers' Compensation Laws and other similar legally established programs. The programs provide benefits for work-related illness or injury.

Promotional Gifts. We may use your confidential health information so that we may provide you with nominal gifts. We will not disclose your confidential information to other companies for their marketing purposes.

Health Related Benefits and Services. We may use and disclose health information to inform you about health-related benefits or services that may be of interest to you. You may be contacted by the Practice regarding general health-related products and services and/or health-related products and services targeted to your specific health status or condition, but only where we believe those products or services may benefit you. If

the communication is targeted to you, it must explain why you were targeted and how the product or service relates to your health. Any communication you receive must identify the Practice as the source of the communication, inform you if we received any payment for making the communication, and contain instructions about how you may request that we not contact you further about such health-related products and services.

Criminal Activity. Under certain Federal and state laws, we may disclose your protected health information if we believe that its use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose your health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Government Functions. We may disclose your health information to the U.S. Military or to authorized federal or state officials for purposes specified by federal law.

Coroners, Funeral Directors, and Organ Donation. We may disclose your health information to a coroner or medical examiner. This may be necessary to identify a deceased person or to determine the cause of death. We may also disclose protected health information to funeral directors as authorized by law to assist them in carrying out their duties. Protected health information may also be used and disclosed for organ eye and tissue donations if you have previously agreed to organ donation.

Parental Access. Various New York State laws determine what protected health information can be disclosed to parents, guardians, and persons acting in a similar legal status. We will act consistently with the law and will make disclosures only when necessary.

Individuals Involved in Your Care. Unless you object, we may use or disclose your health information to notify or assist in the notification of a family member or personal representative of your location, your general condition, or death. If you are present, you will have the opportunity to object to this type of use or disclosure. If you are unable to decide or if it is an emergency, we may disclose information that is directly relevant to the person's involvement in your healthcare, if we determine that it is in your best interest to do so.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

Although your health record is the physical property Rose Hill Psychological Services, PC, the information belongs to you. You have the following rights regarding your protected health information. You may make any of the following requests by completing a "HIPAA Patient Rights Request Form" or by submitting a written request to our office.

Right to Inspect and Copy. You have the right to both inspect and obtain a copy of your protected health information that is contained in a "designated record set" for as long as we maintain your health information. This information is used to make health-related decisions about your care and typically includes professional treatment/progress notes, supplement programs, laboratory reports, prescriptions, and billing/financial records. This request does not include inspection and copying of the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and protected health information that is subject to laws that prohibit access. If you request copies, we may charge you copying and mailing costs.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to health information, you may request that the denial be reviewed.

Right to Request Restrictions. You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care. While we consider all requests for restrictions carefully, we are not required to agree to your request.

Right To Request Amendment. If you believe the health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have a right to request an amendment for as long as the information is kept by or for Rose Hill Psychological Services, PC, if we determine the record is inaccurate.

We may deny your request if it is not in the appropriate form or does not include a reason to support the request. In addition we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment
- Is not part of the information kept by or for Rose Hill Psychological Services, PC is not part of the information which you would be permitted to inspect or copy
- Is accurate and complete

Right to Request Confidential Communications. You may request that we communicate with you using alternative means or at an alternative location. You may also ask that we mail information to you in a sealed envelope rather than a postcard. While we will consider this request carefully, we are not required to agree to all requests.

Right to Request an Accounting of Disclosures. You have the right to an accounting of disclosures. This is a list of where we have sent your protected health information that does not include disclosures made for treatment, payment, or healthcare operations as described in this notice. Your request must state a time period beginning on or after April 14, 2003, and no more than 6 years from the date of request.

Right To Obtain a Copy of this Notice. You have the right to a paper copy of this notice. You may request a copy of this notice at any time. To obtain a copy of this, please contact the Practice Administrator or his/her designee.

CHANGES TO THIS NOTICE

We reserve the right to change our privacy practices and this notice. We reserve the right to make changed notice effective for health information we already have about you as well as any information we receive in the future. If we change the notice, we will provide each active patient with a new notice. You may also obtain a new notice by calling our office.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with Rose Hill Psychological Services, PC Privacy Officer or his/her designee at the address below. No retaliation will occur against you for filing a complaint. All complaints must be submitted in writing. You may also file written complaints with the Secretary of the US Department of Health and Human Services. Please call our office to obtain the correct address for the Secretary.

Rose Hill Psychological Services, PC
HIPAA Privacy Officer
330 West 58th Street, Suite 409
New York, NY 10019

OTHER USES OF YOUR HEALTH INFORMATION

Other uses and disclosures of your health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose your health information, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose your health information for the reasons covered by your written authorization. We are unable to take back any disclosures we have already made with your permission and we are required to maintain in our records of the care that we provided to you.

This notice was published on June 24, 2014 and all provisions become effective by Federal Law on April 14, 2003. Our Notice of Privacy Practices remains in effect until modified by Rose Hill Psychological Services, PC.



Beech Street

ARUP

NAP

OVE ARUP & PARTNERS PC

GRP: 2311745-015-00001
Issuer (80840) 9140860054
Choice POS 11

ID W2620 17029

NAME
01 RYAN M COX

PCP: NO ELECTION REQUIRED

RX BIN# 610502

PCP \$ 35.00
SPC \$ 35.00

PAYER NUMBER 60054 0131
www.aetna.com
TALK TO A DOCTOR 24/7: 1-855-TELADOC OR TELADOC.COM/AETNA.
For Informed Healthline call: 1-800-556-1555
You do not have to choose a primary care doctor. Referrals are not required. However, some services may also require pre-certification. Without pre-approval, you may pay more or even full price. For mental health or substance abuse pre-approval or coverage questions, call 1-800-424-4047. See your plan documents for information on your plan requirements. In an emergency call 911 or go to the nearest emergency room. Note: This card does not guarantee coverage.

Aetna Life Insurance Company
P.O. Box 14079
LEXINGTON KY 40512-4079

AETNA CONCIERGE
PROVIDERS CALL
RX MEMBER SERVICES

1-866-984-2246
1-888-632-3862
1-888-792-3862