Lubna Somjee, Ph.D.
Licensed Psychologist

Patient Name _____ DOB _____ Patient Ins ID _____

Name _____ DOB _____

Complete address _____Sex assigned at birth _____

Marital status: Single/Married/Other Preferred pronoun: He She They Other

Race and/or ethnic background _____

Telephone

Cell _____ OK to call _____ OK to leave a message _____

Home _____ OK to call _____ OK to leave a message _____

Work _____ OK to call _____ OK to leave a message _____

Email address (*one time use only to provide telehealth link*) _____

Insurance company name and address _____

Insurance ID _____. Insurance phone _____

Policy Holder (if other than patient)

Name _____ DOB _____

Address _____ Gender _____

What is your relationship to the insured? Self Spouse Child Other

If you have a secondary insurance, please provide name of insurance company, address and ID #

_____

Policy Holder (if other than client)

Name: _____ DOB _____

Address: _____ Gender _____

Is patient condition related to: Employment Y or N Auto accident Y or N Other accident Y or N

Permission for the Treatment of Minors:

I hereby given Lubna Somjee, Ph.D., permission for the duration of psychotherapy, to evaluate and treat.

I am authorizing Lubna Somjee, Ph.D. to work with my insurance company to pay her for services rendered (Please sign below)

_____ _____

Patient Date

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Consent to Release Information to your Primary Care Physician

Communication between health professionals, including your PCP, can be important to help ensure you receive comprehensive and quality healthcare. This information will not released though your consent. Such information can include diagnosis, treatment plan, process and current medications. You may revoke this consent at any time.

I, _____ DOB _____ for the purposes of coordinating my mental health/substance abuse treatment and medical healthcare, authorize Lubna Somjee, Ph.D. to release information to my PCP _____. The information exchanged may include information on mental health or substance abuse treatment.

For Alcoholism and Substance Abuse Treatment: I understand this disclose is bound by Title 42 of the Federal Regulations governing confidentiality of alcohol and substance abuse patient record and redisclose to another party, other than the one designated above is forbidden without additional authorization.

This authorization is valid for one year. I, the undersigned understand that I may revoke this consent anytime by written notice to Lubna Somjee, Ph.D. Revocation will not cover information released prior to revocation date. I understand that it is my responsibility to notify Dr Lubna Somjee, PH.D. if I change my PCP. I have read the above and given my consent.

- Please Check Only One Option -

_____ To release any applicable mental health and medical information to my PCP

_____ To release only medication information to my PCP

_____ I do not give consent to releasing any information to my PCP

Primary Care Providers name, complete address and phone number

_____

_____

_____ _____
Patient signature Date

_____ _____
Parent/Guardian signature Date

_____ _____
Lubna Somjee, Ph.D. Date

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Patient Rights and Responsibilities

Welcome to my practice. The following outlines information regarding my profession series and business practices. You have also been given information about the Health Insurance Portability and Accountability act (HIPAA). HIPAA requires that I provide you with a Notice of Private Practices for use and disclosure of Protected Health Information (PHI) for treatment, payment and healthcare operations. Please read all documents and feel free to ask questions.

Psychotherapy: Psychotherapy varies depending on the needs and personality of the patient and psychotherapist, and the particular problems you are experiencing. Psychotherapy is not like a medical doctor visit. Instead it calls for active effort on your part but during and in between sessions. Psychotherapy can have benefits and risks. Since it often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness and helplessness. Psychotherapy has shown to have many benefits. These can include better relationships, solutions to problems, and reduction of distressing feelings. However, there are no guarantees of what you will experience. Initially, an evaluation will be completed so I can offer you initial impressions and treatment plan. Sessions will be 45 minutes once a week.

Confidentiality: There are federal and state laws, and professional ethics that protect patient confidentiality. All material within treatment is confidential, with some exceptions. No information regarding your participation in psychotherapy will be released without your written permission. Exception included if I suspect a patient is at imminent risk for hurting themselves or others. If I suspect abuse or neglect of a minor,I am required by law to report to the appropriate agency. Other exceptions included where state of federal law prevail including, but not limited, to our orders. You should be aware that most insurance company do require information regarding your treatment. By signing you agree that I can provide requested information to your insurance company. Occasionally, I may find it helpful to consult with other healthcare professionals about a case. During the consult, I make every effort to avoid revealing the identity of the patient. I note all consults in your chart. Further aspects of confidentially, of PHI are detailed in the guide to HIPAA flyer given to you today.

Fee: My fee is $220 for the initial session and $180 for subsequent sessions (individual therapy). Payment of fees is due at the time services are rendered. Prior to treatment you are required to complete this form and a health insurance form if applicable. If your psychotherapy is covered by your insurance, you are responsible for any deductible, co-pay or co-insurance at the beginning of each session. If any or all of your treatment is not covered by your insurance company for any reason, you may be responsible for payment.

In addition to weekly appointments, I may charge this amount for other professional services you may need, though I will break down the session cost if I work for periods of less than one hour. If you become involved in legal proceeding that require my participation, you may be asked to cover all my professional time including preparation, transportation and attendance. Because of the difficulty of legal involvement, I may charge between $300-400 an hour.

Should a check bounce, there will be a bounced check fee. In the event an account becomes 90 day past due, professional collections may be utilized or legal action taken. If that is necessary, the cost will be included in the claim.

Contacting Me: You can reach me by calling my office phone number. I monitor my voicemail during business and after hours.If you are unable to reach me and it's an emergency, dial 911 or call the Dutchess County Helpline: 845-485-9700.I will likely be using a cell phone to call so please inform me immediately if this is problematic. *Please do not contact me via email, text or any other platform.*

Lubna Somjee, Ph.D.
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Appeals and Grievances: I understand I have a right to request an appeal from the insurance company if outpatient care is not authorized. I understand the request for appeal can me made to my insurance company and I risk nothing in exercising that right. I understand that to submit a complaint or grievance, I may contact the customer service department of my health plan.

Consent: I further authorize and request that Lubna Somjee, Ph.D. carry out psychological examinations, treatment and or diagnostic procedures which now or during the course of my care as a patient are advisable. I understand I can ask questions regarding the purpose of these procedures and that I have the right to be aware of all aspects of the working relationship. I understand that I have the right to participate actively in all aspects of treatment planning and that I can discontinue treatment at any time. I also understand that while the course of therapy is designed to be helpful, it may at times be difficult and uncomfortable.

Missed Appointments: Failure to give 48 hours notice of cancellation will result in a charge of $75 unless we both agree that you were unable to attend due to certain circumstances beyond your control (you are ill, someone you look after or are responsible for has a 911 emergency, or hazardous weather conditions).

I have read and understand the above information regarding my rights and responsibilities.

_____ _____

Patient signature Date

Receipt and Acknowledgement of Notice

HIPAA: I hereby acknowledge that I have received and have been given an opportunity to read explanatory information regarding HIPAA and can request a copy of complete privacy practice guidelines at any time. I understand if I have any questions regarding the Notice or my privacy rights, I can contact Lubna Somjee, Ph.D.

_____

Print Name of Patient

_____ _____

Patient signature Date

Lubna Somjee, Ph.D.
Licensed Psychologist

Patient Name _____ DOB_____ Patient Ins ID _____

Office Procedures: Telemedicine Consent

During this period, when people are concerned about their health and safety due to the COVID-19 outbreak, I am trying to continue our sessions as normally as possible, but there are some precautions I am taking given patients and family members who are immune compromised.

First and foremost please ask instead for a telehealth visit if:
* You are sick (coughing, sneezing, or have a fever, PLEASE cancel your appointment!
* You have been around someone with COVID
* You have traveled or visited locations known to have multiple cases/community spread of COVID-19
* You have family members who have symptoms of COVID

Second, please bring hand sanitizer and utilize it.

Please note, if you arrive and are symptomatic, you will be asked to leave the office and charge a cancellation fee

Videoconferencing Option: Most insurance companies will reimburse for video-conferencing. Depending on how things progress, I may prefer to videoconference instead of meeting in person. If so, this will only be used for specific circumstances. If for some reason your insurance company refuses to pay for services, you would be responsible for my fee.

I hereby consent to engaging in telemedicine with Lubna Somjee, PhD, as part of my psychotherapy. I understand that "telemedicine" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical/mental health data, and education using interactive video, audio, or data communications.

I understand that I have the following with respect to telemedicine:

Benefits and Risks of Telepsychology
Telepsychology refers to providing psychotherapy services remotely using telecommunications technologies, such as video conferencing or telephone. One of the benefits of telepsychology is that the client and clinician can engage in services without being in the same physical location. Telepsychology, however, requires technical competence on both our parts to be helpful. Although there are benefits of telepsychology, there are some differences between in-person psychotherapy and telepsychology, as well as some risks. For example:

- Risks to confidentiality. Because telepsychology sessions take place outside of the therapist's private office, there is potential for other people to overhear sessions if you are not in a private place during the session. On my end I will take reasonable steps to ensure your privacy. But it is important for you to make sure you find a private place for our session where you will not be interrupted. It is also important for you to protect the privacy of our session on your cell phone or other device. You should participate in therapy only while in a room or area where other people are not present and cannot overhear the conversation.

- Issues related to technology. There are many ways that technology issues might impact telepsychology. For example, technology may stop working during a session, other people might be able to get access to our private conversation, or stored data could be accessed by unauthorized people or companies.

- Crisis management and intervention. Usually, I will not engage in telepsychology with clients who are currently in a crisis situation requiring high levels of support and intervention. Before engaging in telepsychology, we will develop an emergency response plan to address potential crisis situations that may arise during the course of our telepsychology work.

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- Efficacy. Most research shows that telepsychology is about as effective as in-person psychotherapy. However, some therapists believe that something is lost by not being in the same room. For example, there is debate about a therapist's ability to fully understand non-verbal information when working remotely.

Electronic Communications
We will decide together which kind of telepsychology service to use. You may have to have certain computer or cell phone systems to use telepsychology services. You are solely responsible for any cost to you to obtain any necessary equipment, accessories, or software to take part in telepsychology.

For communication to log onto sessions, I will use email communication with your permission. This means that **email exchanges will be limited to connecting to your tele psychology session only.** You should be aware that I cannot guarantee the confidentiality of any information communicated by email. Therefore, I will not discuss any clinical information by email or text and prefer that you do not either. Also, I do not regularly check my email, messaging app on the tele psychology platform etc, nor do I respond, so these methods should not be used if there is an emergency.

Treatment is most effective when clinical discussions occur at your regularly scheduled sessions. But if an urgent issue arises, you should feel free to attempt to reach me by phone. I will try to return your call within 24 hours except on weekends and holidays. If you are unable to reach me and feel that you cannot wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist or psychiatrist on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact in my absence if necessary.

Confidentiality
I have a legal and ethical responsibility to make my best efforts to protect all communications that are a part of our telepsychology. However, the nature of electronic communications technologies is such that I cannot guarantee that our communications will be kept confidential or that other people may not gain access to our communications. I will try to use updated encryption methods, firewalls, and back-up systems to help keep your information private, but there is a risk that our electronic communications may be compromised, unsecured, or accessed by others. You should also take reasonable steps to ensure the security of our communications (for example, only using secure networks for telepsychology sessions and having passwords to protect the device you use for telepsychology). The extent of confidentiality and the exceptions to confidentiality that I outlined in my Informed Consent still apply in telepsychology. Please let me know if you have any questions about exceptions to confidentiality.

Appropriateness of Telepsychology
From time to time, we may schedule in-person sessions to "check-in" with one another. I will let you know if I decide that telepsychology is no longer the most appropriate form of treatment for you. We will discuss options of engaging in in-person counseling or referrals to another professional in your location who can provide appropriate services.

Emergencies and Technology
Assessing and evaluating threats and other emergencies can be more difficult when conducting telepsychology than in traditional in-person therapy. To address some of these difficulties, we will create an emergency plan before engaging in telepsychology services. I will ask you to identify an emergency contact person who is near your location and who I will contact in the event of a crisis or emergency to assist in addressing the situation.

If the session is interrupted for any reason, such as the technological connection fails, and you are having an emergency, do not call me back; instead, call 911, or go to your nearest emergency room. Call me back after you have called or obtained emergency services.

If the session is interrupted and you are not having an emergency, disconnect from the session and I will wait two (2) minutes and then re-contact you via the telepsychology platform on which we agreed to conduct therapy. If you do not receive a call back within two (2) minutes, then call me at 845-380-2945.

Lubna Somjee, Ph.D.
Licensed Psychologist

Patient Name _____ DOB_____ Patient Ins ID _____

Fees
The same fee rates will apply for telepsychology as apply for in-person psychotherapy. However, insurance or other managed care providers may not cover sessions that are conducted via telecommunication. If your insurance, HMO, third-party payor, or other managed care provider does not cover electronic psychotherapy sessions, you will be solely responsible for the entire fee of the session. Please contact your insurance company prior to our engaging in telepsychology sessions in order to determine whether these sessions will be covered.

Records
The telepsychology sessions shall not be recorded in any way unless agreed to in writing by mutual consent. I will maintain a record of our session in the same way I maintain records of in-person sessions in accordance with my policies.

I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled. I have read and understand the information provided above and understand that when I sign, it will represent an agreement between us. I have discussed it with my psychotherapist, and all of my questions have been answered to my satisfaction.

PRIVACY NOTICE:
Please be aware that in the event any of my patients, office colleagues, building personnel, or myself is suspected of having COVID-19, the NYS Department of Health and/or the CDC (or other official institutions) may require disclosure of names/addresses/phone numbers of all persons I have been in contact with. Normally, privacy rules prohibit this disclosure, but during outbreaks of illness where other people can be in danger, I would be obligated to provide this information to the authorities in order to prevent further spread of the disease. If you are uncomfortable with this possibility, we will have to cancel all sessions until this outbreak has resolved.

As always, your safety and well-being is my top priority. If you're unsure as to whether or not to come in, please feel free to reach out and we can discuss it together.

Patient Signature: _____ Date: _____

Lubna Somjee, Ph.D. _____ Date: _____

Lubna Somjee, Ph.D.
Licensed Psychologist

NOTICE OF PRIVACY PRACTICES
(For Patient to Keep)

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. If you have any questions about this Notice please contact our Privacy Officer, Lubna Somjee, Ph.D.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act ("HIPAA"), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules, and the NYSPA Code of Ethics. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment.
Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment.
We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations.
We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization.
Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations. As a psychologist licensed in this state and as a member of the New York State Psychological Association, it is our practice to adhere to more stringent privacy requirements for disclosures without an authorization. The following language addresses these categories to the extent consistent with the APA Code of Ethics and HIPAA.

Child Abuse or Neglect. We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.
Judicial and Administrative Proceedings. We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.
Deceased Patients. We may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.
Medical Emergencies. We may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.
Family Involvement in Care. We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.
Health Oversight. If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.
Law Enforcement. We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.
Specialized Government Functions. We may review requests form U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.
Public Health. If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.
Public Safety. We may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.
Research.
PHI may only be disclosed after a special approval process or with your authorization.
Fundraising.
We may send you fundraising communications at one time or another. You have the right to opt out of such fundraising communications with each solicitation you receive.
Verbal Permission.
We may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.
With Authorization.
Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications, (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

YOUR RIGHTS REGARDING YOUR PHI
You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer at Lubna Somjee, Ph.D.

Right of Access to Inspect and Copy.
You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set". A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.
Right to Amend. If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.
Right to an Accounting of Disclosures. You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
Right to Request Restrictions. You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.
Right to Request Confidential Communication. You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate reasonable requests. We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. We will not ask you for an explanation of why you are making the request.
Breach Notification. If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.
Right to copy of this Notice. You have the right to a copy of this notice.

COMPLAINTS
If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer at Lubna Somjee, Ph.D. or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, DC 20201 or by calling (202) 619-0257. We will not retaliate against you for filing a complaint.

The effective date of this Notice is September 2013.