

**Information Form**

**Dr. Shoshana Hellman**

**68, Sokolov St. # 12**

**Ramat Hasharon**

**PLEASE PRINT AND COMPLETE ALL ENTRIES**

**Today's Date:** \_\_\_\_\_

\_\_\_\_\_  
Name (First, Middle Initial, last)      Date of Birth      Marital Status

\_\_\_\_\_  
Address (Street City State)      Zip Code      Home Phone#

\_\_\_\_\_  
E-mail Address      Cell Phone#

\_\_\_\_\_  
Employer's Name

\_\_\_\_\_  
Emergency Contact      Relationship      Phone #

# **Treatment, Privacy and Financial Policies**

## **TREATMENT CONSENT AND PATIENT RIGHTS**

I consent to treatment as agreed upon with my clinician. I understand my patient rights and that I have received a written copy of these rights upon request.

## **DISTANCE COUNSELING**

As your therapist I have selected an account with Zoom.us for video communications to allow for the highest possible security and confidentiality of the content of your sessions. In order to benefit from these safeguards, you are required to download, register and utilize the chat and video software from [zoom.us](https://zoom.us) and use additional safeguards when the computer used to access services may be accessed by others. In case of technical difficulties, please call me immediately on my cell phone in order to provide continuity to the session. (+972522330298 )

## **CANCELLATION POLICY**

Twenty four (24) hour advance notice is required for cancellation of appointments. I am aware that I will be charged a missed appointment fee, as customary.

## **PRIVACY NOTICE**

Included on the second page is a copy of the Privacy Notice as required by the Federal Health Insurance Portability and Accountability Act related to legal duties with respect to health information.

## **FINANCIAL AGREEMENT AND COMMUNICATION**

The fee for a session of one hour is 450 shekel, or, 150 dollars , to be paid immediately following the session. (via check, money transfer, bit, Zelle ) A receipt will be provided.

Communication with the provider between sessions can be done via email:

[shoshana.hellman@gmail.com](mailto:shoshana.hellman@gmail.com)

Or cell phone: 052-2330298 (Israel) 1-414-324-8879 (WhatsApp)

**ACKNOWLEDGEMENT AND NOTIFICATION**

I acknowledge that I was provided with an explanation of cancellation, emergency, financial and privacy policies; the second page of this package is to be taken with me.

**I have read and agree to the policies stated above.**

Patient signature:

Date:

\_\_\_\_\_

\_\_\_\_\_

You have several rights with regard to your health information. If you wish to exercise any of the following rights, please contact your individual provider. Specifically, you have the right to: **1) *Inspect and copy your health information.*** With a few exceptions, you have the right to inspect and obtain a copy of your health information. However, this right does not apply to psychotherapy notes or information gathered for judicial proceedings, for example. In addition, we may charge you a reasonable fee if you want a copy of your health information. **2) *Request to correct your health information.*** If you believe your health information is incorrect, you may ask us to correct the information. You may be asked to make such requests in writing and to give a reason as to why your health information should be changed. However, if we did not create the health information that you believe is incorrect, or if we disagree with you and believe your health information is correct, we may deny your request. **3) *Request restrictions on certain uses and disclosures.*** You have the right to ask for restrictions on how your health information is used or to whom your information is disclosed, even if the restriction affects your treatment or our payment or health care operation activities. You can ask to limit the health information provided to family or friends involved in your care or payment of medical bills. However, we are not required to agree in all circumstances to your requested restriction. **4) *As applicable, receive confidential communication of health information.*** You have the right to ask that we communicate your health information to you in different ways or places. We must accommodate reasonable requests. **5) *Receive a record of disclosures of your health information.*** In some limited instances, you have the right to ask for a list of the disclosures of your health information we have made during the previous six years. **6) *Obtain a paper copy of this notice.*** Upon your request, you may at any time receive a paper copy of this notice. **7) *Complaints.*** If you believe your privacy rights have been violated, you may file a complaint with us and with the federal Department of Health and Human Services.

Again if you have any questions or concerns regarding your privacy rights or the information in these notices, please contact me, his notice of Medical Information Privacy is a Federal regulation (HIPPA). Effective 4/14/2003.

Dr. Shoshana Hellman