Laila El-Asmar, LCSW-C, LLC
4828-B West Lane Bethesda, MD 20814
(202) 701-0051
Laila.elasmarlcswc@gmail.com and www.lailaelasmar.com

PATIENT INFORMATION SHEET

Name: ____ Sex at birth Male [ ] Female [ ]
Date of Birth: ____________________
Address:____
Work Phone: (_____) ___- ______ Home: (_______) - _______________ Cell: (______) __ - _______

Email: ___________________________________ Text: _________________________
Messages (circle): Work / Home / Cell / Email / Text
Marital Status: Single ________ Married ________ Other ___________________________

Referring Physician: ____________________ Phone: __________________________
Employer Address: ______________________ City: ___________________
State: ___________ Zip: ______________

EMERGENCY CONTACT

Name: ______________________________Phone: ____________________________
Relationship to Patient: ____

INSURANCE

PRIMARY INSURANCE (Note: You are required to fill in all fields)

Primary Insurance: __________________________ ____________________
Phone: (______) ______________
Insurance Co. Address: ____
City: _______________________State:________________ Zip: ______________
Name of Subscriber: ____
Subscriber's date of birth: ____
ID No: ____________________________ Group No: ___________________________
Relationship to patient: ____

SECONDARY INSURANCE (Note: You are required to fill in all fields)
Secondary Insurance: __________________________ ____________________
Phone: (______) ______________
Insurance Co. Address: ____
City: _______________________State:________________ Zip: ______________
Name of Subscriber: ____
Subscriber's date of birth: ____
ID No: ____________________________ Group No: ___________________________
Relationship to patient: ____

______ I authorize Laila El-Asmar, LCSW-C, LLC to furnish my insurance carrier with all information necessary to process my claim for services rendered. In regards to MEDICARE - I understand that reimbursement for some services deemed necessary and explained to me, may not be covered under MEDICARE and may be denied for payment. I will be responsible for such charges. With regards to Managed Care/Referral Plans, I understand that it is my responsibility to request referrals from my Primary Care Physician in advance and to be aware of the number of allowable visits. I have read and agree to the above information.
OR
__ I choose not to use my insurance and will pay privately.
Patient Signature:___________________________Date:___________________________

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Practice Policies

One of the most curative aspects of a therapeutic relationship is the goodness of fit between therapist and patient. The initial visit is the opportunity to determine if I am the right therapist for you. I reserve the right to decline to take your case based on goodness of fit. Should I choose to continue with you in practice, the following policies apply:

Office Hours: Office hours are Tuesday through Friday 9:00 am to 5:00 pm, by appointment only. Voicemail messages left on Friday, Saturday or Sunday will **not** be returned until the following Monday.

Insurance: I participate in a number of insurance plans and I will submit your insurance claim for services rendered if you provide me with valid insurance information at our first appointment. I also require an additional form of photo identification such as a driver's license. Being a participating provider means that I accept what the insurance plan allows, however the patient is still responsible for that portion allowed, but not paid by the insurance company, such as any deductibles and co-payments. If your insurance changes at any time, and you fail to notify me, you will be responsible for the private pay amount of **$140.00-$180.00 per session.**

Fees: Payment is due at the time service is rendered. Fees are based on the service provided, your insurance coverage, and the length of the sessions. **Sliding Scale is available**. Please contact me directly. The cost of my services is as follows:

Initial Assessment Session including Telehealth Sessions (60 minutes): $180.00
Individual Psychotherapy Session including Telehealth Sessions (55 minutes): $160.00
Individual Psychotherapy Session including Telehealth Sessions (45 minutes): $140.00
Family Psychotherapy Session including Telehealth Sessions (55 minutes): $175.00
Couples Psychotherapy Session including Telehealth Sessions (55 minutes): $175.00
Report/Letter Writing – 30 minutes: $60.00
Treatment Related Phone Calls – 5-15 minutes: $65.00
Treatment Related Phone Calls – 15-30 minutes: $40.00
Missed Appointment Fee- Less than 24 hour notice of cancelation:
(Your health insurance does **NOT** pay/reimburse for this):$160.00

Payment Policy: Payments will be due prior to the beginning of each session. Unless other arrangements are made in advance, all accounts that are outstanding for more than 90 days will be sent to collections. Payments can be made by cash, check or credit card. I accept Visa, Master Card, Discover, PayPal & Venmo. If someone other than you is responsible for your bills, I will bill them each month for my services. I reserve the right to suspend treatment with you if payment is not received within a month of receipt.
There is a $30.00 fee for returned checks.

Inclement Weather: If I am unable to get to the office due to inclement weather, I will contact you immediately, by phone, text or email, to reschedule your appointment. Please assume that I will be in the office, unless you hear from me directly. If you can't get to the office due to weather conditions, please notify me as soon as you can. You will not be billed if you need to cancel for this reason.

Confidentiality: Everything that we discuss will be considered confidential information. I will not share any confidential information with anyone without your written permission. However, I may disclose confidential information without your permission if you are in imminent, serious danger of harming yourself or another person or if you are abusing or neglecting a child or a vulnerable disabled/older adult, or if I am subpoenaed by a judge.

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Treatment of Minors with Separated/Divorced Parents: Please be aware that if you are a separated/divorced parent and your child or adolescent is going to begin treatment with me, you must provide a copy of the divorce agreement before treatment begins. The agreement should stipulate which parent is authorized to have their child/adolescent engage in therapeutic services.

Referrals: It is the patient's responsibility to obtain proper Primary Care Physician referrals **PRIOR** to their first office visit. Treatment will not begin without the proper referral. Please check with your insurance company prior to making your first appointment to see if other authorizations are required.

Appointment Changes/ Cancellations: As sessions are 45-60 minutes, if you are late, you will only be allowed the time remaining. If you must reschedule or cancel an appointment, I require at least **24-hour notice** (weekends not included). Cancellations can be made by calling my cell number and leaving a voicemail message. Cancellations that occur with less than 24-hour notice or failure to show to an appointment will be charged the fee of **$160.00.** As insurance companies do not cover missed appointment fees, patients utilizing insurance will be personally responsible for full payment of cancelled or missed sessions. If two appointments are missed without notice, any remaining appointments will be cancelled. If, for any reason, I must cancel an appointment, you will be notified at the earliest possible time.

Medical Records: Records can be sent directly to another health care provider, for a fee, upon your request. Please provide at least 72 hours notice and your request in writing, sign by the patient. Patients may receive a copy of their medical record, by written request, for a fee of $18.l6 plus $.60/page, payable at the time of receipt. Costs are estimated in accordance with Maryland Annotated Code, subject to change, currently $18.16 plus $.60/page, plus postage.

Patient Privacy: I am committed to securing the privacy of your health information. I am providing you with a copy of my Notice of Health Information Practices. Your signature below acknowledges that you have received and read the copy of my Notice of Health Information Practices.

I have read and accept these policies. I hereby assume financial responsibility and agree to make payment in full to Laila El-Asmar, LCSW-C, LLC for any and all charges received by me and/or my dependents not otherwise authorized or paid by my insurance carrier, unless I have chosen not to use my insurance as specified on page 1. I authorize the release of any medical information necessary to process my insurance claim forms and authorize payment of medical benefits to Laila El-Asmar LCSW-C, LLC.

Patient Signature: ____

Date:____

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RELEASE OF INFORMATION AND ASSIGNMENT OF INSURANCE BENEFIT

Billing Policy:
Laila El-Asmar LCSW-C, LLC will bill any insurance company that she participates with in accordance with her contracts. Subsequent deductibles and co-payments will be collected at the time of service and are the responsibility of the patient. For insurance companies she does not participate with, an itemized statement will be provided to the patient to submit to their insurance company. Full payment is due from the patient at the time of service.

Patient Consent: Consent allows Laila El-Asmar LCSW-C, LLC to use or disclose protected health care information to carry out treatment, payment and health care operations.
I authorize the release of any medical information necessary to process claims. I also request payment of government benefits to the party who accepts assignment below.
I understand that my insurance (including Medicare) may not cover all/part of the charges of Laila El-Asmar, LCSW-C, LLC. I hereby consent to these services and agree to pay for any charges that my insurance does not cover.

I understand that I am financially responsible for all charges not covered by this assignment. I understand that I am financially responsible for any deductible on my insurance and any co-insurance (co-pay). I authorize payment of medical benefits to Laila El-Asmar, LCSW-C, LLC.

_____I choose **not** to use my insurance and will pay privately. I understand that I am responsible for any additional costs/fees associated with collection or attorney expenses regarding
past due account balances.

Patient Signature: ____

Date: ____

HMO/PPO Patients:

My insurance does ____does not _____ require referrals from my Primary Care Physician.

My insurance does ____ does not ____ require pre-certification from them for services.

I know that without a referral, I will be held financially responsible for any charges not paid by my insurance carrier. I further know that if I have an HMO plan with a PPO option and come for a visit without the necessary authorization or referral, I am going outside my network and will be considered under the PPO portion of the plan.
IT IS NOT THE RESPONSIBILITY OF LAILA EL-ASMAR LCSW-C, LLC TO KNOW MY INSURANCE PLAN REQUIREMENTS.

Patient Signature: ____

Date: ____

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NOTICE OF HEALTH INFORMATION PRACTICES EFFECTIVE DATE APRIL 1, 2005

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

Introduction: I am committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information I collect, and how and when I use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective April 1, 2005 and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record Information: Each time you visit me, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnosis, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:
basis for planning your care and treatment
means of communication among the many health professionals who contribute to your care
legal document describing the care you received
means by which you or a third-party payer can verify that services billed were actually
provided tool in educating health professionals
source of information for public health officials charged with improving the health of this state and the nation
source of data for planning and marketing
tool with which I can assess and continually work to improve the care I render and the outcome I achieve.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosures to others.

Your Health Information Rights:
Although your health record is the physical property of Laila El-Asmar, LCSW-C*,* LLC, the information belongs to you. You have the right to:
obtain a paper copy of this notice of information practices upon written
request inspect and receive a copy of your health record
obtain an accounting of disclosures of your health information
request communications of your health information by alternative means or at alternative locations
revoke your authorization to use or disclose health information except to the extent that action has already been taken.
My Responsibilities: My office is required to:
maintain the privacy of your health information
provide you with this notice as to my legal duties and privacy practices with respect to information I collect and maintain about you.
abide by the terms of this notice
notify you if I am unable to agree to a requested restriction
accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

I reserve the right to change my practices and to make the new provisions effective for all protected health information I maintain. I will not use or disclose your health information without your authorization, except as described in this notice. I will also discontinue to use or disclose your health information after I received a written revocation of the authorization according to the procedures included in the authorization.

For More Information or To Report a Problem: If you believe your privacy rights have been violated, you can file a complaint with Laila El-Asmar LCSW-C, LLC. or with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

Examples of Disclosures For Treatment, Payment and Health Operations I will use your health information for treatment. For example: Information obtained by a member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you.

I will use your health information for payment. For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

I will use your health information for regular health operations. For example: Members of the staff may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the health care and service I provide.

Notification: I may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition. I may leave a message on your voicemail/email/text as a means of communication. I may also mail you a written notice as a means of communication.

Communication With Family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Funeral Directors: I may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Organ Procurement Organizations: Consistent with applicable law, I may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Food and Drug Administration (FDA): I may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs or replacement.

Workers Compensation: I may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public Health: As required by law, I may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.

Law Enforcement: I may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena. Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that I have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF HEALTH INFORMATION PRACTICES

I acknowledge that I have been provided Laila El-Asmar LCSW-C, LLC's ("LEA") Notice of Health Information Practices ("Notice"):

The Notice tells me how LEA will use my health information for the purposes of my care and treatment, payment for my treatment and for regular health operations.

The Notice explains in more detail how LEA may use and share my health information for purposes other than treatment, payment and health operations.

LEA will also use and share my health information as required/permitted by law.

Patient Signature: ____

Date: ____