Ira Practice

325 Sentry Parkway, 5 West, 200 Suite 200 Blue Bell PA 19422-2958

2026 Consents and Authorizations

SECTION 1: PATIENT REGISTRATION & DEMOGRAPHIC INFORMATION

Please provide accurate and complete personal information. This information is required to establish your patient record.

1 **Patient Full Legal Name**

Patient Name

2 **Date of Birth** *

MM/DD/YYYY

3 **Biological Sex** *

Male | Female | Intersex | Prefer Not to Say

4 **Preferred Pronouns**

He/Him | She/Her | They/Them | Ze/Zir | Prefer Not to Say | Other

5 **Marital Status**

Single | Married | Domestic Partnership

Divorced | Widowed | Separated

Prefer Not to Say

6 Preferred Method of Contact *

Phone Call | Text/SMS | Email

Patient Portal Message | Mail

7 Do you require an interpreter?

Yes | No

8 Employment Status

Employed Full-Time | Employed Part-Time | Self-Employed

Unemployed | Student | Retired

Disabled | Homemaker | Prefer Not to Say

9 Employer Name (if applicable)

Short answer

10 Emergency Contact Information *

Contact

11 Referring Provider / How did you hear about us?

Referring Physician/Provider | Insurance Company | Friend or Family

Internet/Web Search | Social Media | Health Fair/Community Event

TV/Radio Advertisement | Walked In | Other

EAP Referral

12 **Referring Provider Name (if applicable)**

SECTION 2: INSURANCE & BILLING INFORMATION

Please provide your insurance information. Accurate billing information ensures timely and correct processing of your claims.

13 **Primary Insurance Information**

Insurance

14 **Primary Insurance Policy Holder Information**

Policy Holder

15 **Do you have secondary insurance?**

Yes No

16 **Secondary Insurance Information (if applicable)**

Secondary

17 **Assignment of Benefits Authorization-I hereby agree that payment for services should be paid directly to the Provider** *

I Authorize Assignment of Benefits

I Do Not Authorize Assignment of Benefits

SECTION 3: MEDICAL HISTORY & HEALTH INFORMATION

Please provide a complete and accurate medical history. This information is essential for providing you with safe and

effective medical care.

18 Primary Reason for Visit / Chief Complaint *

Long answer

19 Past Medical History / Active Diagnoses *

Hypertension (High Blood Pressure)	Diabetes (Type 1)	Diabetes (Type 2)
Pre-Diabetes	Heart Disease / Coronary Artery Disease	Congestive Heart Failure (CHF)
Atrial Fibrillation (AFib)	Stroke / TIA	High Cholesterol / Hyperlipidemia
Asthma	Chronic Obstructive Pulmonary Disease (COPD)	Sleep Apnea
Thyroid Disease (Hypothyroid/Hyperthyroid)	Kidney Disease / CKD	Liver Disease / Hepatitis
Gastroesophageal Reflux Disease (GERD)	Irritable Bowel Syndrome (IBS)	Inflammatory Bowel Disease (Crohn's/Colitis)
Arthritis (Osteoarthritis)	Arthritis (Rheumatoid)	Lupus / Autoimmune Disease
Cancer (current or history)	Depression	Anxiety
Bipolar Disorder	ADHD/ADD	PTSD

Schizophrenia	Substance Use Disorder	HIV/AIDS
Epilepsy / Seizure Disorder	Migraine Headaches	Osteoporosis
Anemia	Fibromyalgia	Chronic Pain
Obesity	None of the Above	Other (please describe below)

20 **Please describe any additional medical conditions not listed above**

Long answer

21 **Family Medical History**

Condition	Relationship to Patient	Age of Onset (if known)	Deceased? (Y/N)

22 **Do you have a family history of any of the following? (Select all that apply)**

Heart Disease	Stroke	Diabetes
Cancer (specify type below)	High Blood Pressure	High Cholesterol
Mental Illness	Substance Abuse	Kidney Disease
Autoimmune Disease	Genetic/Hereditary Conditions	None Known
Other		

SECTION 4: SOCIAL HISTORY & LIFESTYLE

The following questions help us understand your lifestyle habits and social factors that may affect your health.

23 **Tobacco / Smoking Status** *

- Never Used Tobacco
- Current Smoker (Daily)
- Current Smoker (Occasional)
- Former Smoker (Quit)
- Smokeless Tobacco / Chewing Tobacco
- E-Cigarette / Vaping (Current)
- E-Cigarette / Vaping (Former)
- Cigar / Pipe (Current)
- Cigar / Pipe (Former)

24 **If former smoker, when did you quit?**

Short answer

25 **Alcohol Use** *

- None / Never
- Occasional (Less than 1 drink/week)
- Social (1-6 drinks/week)
- Moderate (1 drink/day)
- Heavy (More than 14 drinks/week)
- Former User (Currently Abstinent)

26 **Recreational Drug & Legal/ Substance Use**

- None / Never
- Marijuana (Current)
- Marijuana (Former)
- Opioids (Non-prescribed, Current)
- Opioids (Non-prescribed, Former)
- Stimulants (Current)
- Stimulants (Former)
- Benzodiazepines (Non-prescribed, Current)
- Other Substances (Current)
- Other Substances (Former)
- Prefer Not to Answer

27 **Housing Status**

- Stable Housing (Own/Rent)
- Living with Family or Friends
- Transitional Housing / Shelter
- Experiencing Homelessness
- Prefer Not to Say

SECTION 6: REVIEW OF SYSTEMS

Please indicate if you are currently experiencing any of the following symptoms. Select all that apply.

28 **General / Constitutional Symptoms**

- Fever / Chills
- Night Sweats
- Unintentional Weight Loss
- Unintentional Weight Gain
- Fatigue / Weakness
- Loss of Appetite
- None of the Above

29 **Neurological / Mental Health Symptoms**

- Headaches
- Dizziness / Vertigo
- Numbness or Tingling
- Memory Problems / Confusion
- Depression
- Anxiety
- Mood Changes
- Sleep Disturbances / Insomnia
- Thoughts of Self-Harm or Suicide
- None of the Above

30 **If you selected 'Thoughts of Self-Harm or Suicide' above, are you currently having thoughts of harming yourself?**

Yes, I am currently having these thoughts | No, these are past thoughts only | Not Applicable

31 **Additional Symptoms or Concerns**

Long answer

SECTION 7: PRACTICE POLICIES & OFFICE PROCEDURES

Please read the following practice policies carefully. Your acknowledgment and agreement are required before receiving care at our practice.

Appointment Scheduling & Cancellation Policy

All services must be paid for at the time they are rendered. I do not allow any balances to be carried, except in cases where prior approval has been granted. If co-pays are not paid, you may lose the right to keep future scheduled appointments. An invoice will be provided before your scheduled appointment, and payment is expected before the start of the session. (Updated 12/12/2022).

32 **Do you acknowledge and agree to the Financial & Payment Policy?** *

Yes, I Agree to the Financial & Payment Policy | I Have Questions About This Policy

33 ****Acknowledgment of Appointment Scheduling and Cancellation Policy** I hereby acknowledge that I have read, understand, and agree to comply with the Appointment Scheduling and Cancellation Policy of this practice. I understand that psychotherapy sessions are typically scheduled for **45 minutes** unless otherwise**

arranged with the therapist in advance. I agree to provide at **least seventy-two (72) hours' notice** if I need to cancel or reschedule an appointment. I understand that failure to provide the required notice will result in a charge for the full session fee of $125.00, not the copay amount. I understand that all required paperwork must be completed at least seventy-two (72) hours prior to my scheduled appointment. Failure to complete required documentation within this timeframe may result in automatic cancellation of the appointment. I acknowledge that if I arrive late to a scheduled session, the session may still end at the originally scheduled time and I may lose a portion of the session. I further understand that any copayments or balances must be paid prior to the scheduled session. Any unpaid balances may be subject to a 3.5% administrative charge per day until the balance is paid in full. Rescheduled appointments may be canceled if payment arrangements are not made prior to the session start time. I understand that a $125.00 service charge will be assessed for any returned checks due to insufficient funds or for any other reason requiring special handling. I acknowledge that repeated cancellations or rescheduling of regularly scheduled appointments may result in the loss of my reserved appointment time, after which future sessions may be scheduled based on therapist availability. I further understand that missing three (3) consecutive sessions may result in termination of treatment. ***I understand that these policies are necessary because my appointment time is reserved exclusively for me and because consistent attendance is essential for effective treatment.*** By signing below, I acknowledge that I have read, understood, and agree to abide by the terms outlined in this policy. *

Yes, I agree to abide by the policy

No, I have additional questions

After-Hours & Emergency Care Policy- After hours please call my number (215) 661-9515. You may also text me at the number listed above. If you can't wait for a call back, please dial 911 or go to the nearest Emergency Room.

34 **Do you acknowledge and agree to the After-Hours & Emergency Care Policy? I respond usually within 20 minutes of a text. If in crisis after normal hours please call 9-1-1 or go to the nearest ER. ***

Yes, I Agree to the After-Hours Policy

I Have Questions About This Policy

Medical Records & Release of Information Policy

35 **Do you acknowledge and agree to the Medical Records & Release of Information Policy? Under Pennsylvania State Law I am entitled to 30 days to release records. Records are only released with your consent. ***

Yes, I Agree to the Medical Records Policy

I Have Questions About This Policy

Social Media & Photography Policy

36 **Do you acknowledge and agree to the Social Media & Photography Policy? Due to the importance of your confidentiality and the importance of minimizing dual relationships, I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc). I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet and we can talk more about it. Text messaging is a courtesy and not meant to blame me when it doesn't work. ***

Yes, I Agree to the Social Media & Photography Policy

I Have Questions About This Policy

SECTION 8: HIPAA NOTICE OF PRIVACY PRACTICES & OFFICE POLICIES CONSENT

The following section outlines our privacy practices and your rights under the Health Insurance Portability and Accountability Act (HIPAA). Please read carefully.

HIPAA Notice of Privacy Practices

37 Acknowledgment of HIPAA Notice of Privacy Practices-General Rule. The Privacy Rule provides that an individual has a right to adequate notice of how a covered entity may use and disclose protected health information about the individual, as well as his or her rights and the covered entity's obligations with respect to that information. Most covered entities must develop and provide individuals with this notice of their privacy practices. The Privacy Rule does not require the following covered entities to develop a notice: Health care clearinghouses, if the only protected health information they create or receive is as a business associate of another covered entity. See 45 CFR 164.500(b)(1). A correctional institution that is a covered entity (e.g., that has a covered health care provider component).A group health plan that provides benefits only through one or more contracts of insurance with health insurance issuers or HMOs, and that does not create or receive protected health information other than summary health information or enrollment or disenrollment information. See 45 CFR 164.520(a). Content of the Notice. Covered entities are required to provide a notice in plain language that describes: How the covered entity may use and disclose protected health information about an individual.The individual's rights with respect to the information and how the individual may exercise these rights, including how the individual may complain to the covered entity.The covered entity's legal duties with respect to the information, including a statement that the covered entity is required by law to maintain the privacy of protected health information.Whom individuals can contact for further information about the covered entity's privacy policies. The notice must include an effective date. See 45 CFR 164.520(b) for the specific requirements for developing the content of the notice. A covered entity is required to promptly

revise and distribute its notice whenever it makes material changes to any of its privacy practices. See 45 CFR 164.520(b)(3), 164.520(c)(1)(i)(C) for health plans, and 164.520(c)(2)(iv) for covered health care providers with direct treatment relationships with individuals. Providing the Notice. *

- [ ] I Acknowledge Receipt of the Notice of Privacy Practices
- [ ] I Decline to Sign but Acknowledge I Was Given the Opportunity to Review

38 Authorization to Discuss Medical Information

Authorized Person's Full Name	Relationship to Patient	Phone Number	Scope of Authorization (All Information / Limited)

39 Marketing & Communications Opt-In

- [ ] Appointment Reminder Calls
- [ ] Appointment Reminder Text/SMS
- [ ] Appointment Reminder Emails
- [ ] Health Education Newsletters
- [ ] Preventive Care Reminders (e.g., flu shots, annual physicals)
- [ ] Practice News and Updates
- [ ] I Do Not Wish to Receive Any Marketing Communications

SECTION 9: TELEHEALTH TREATMENT CONSENT

Please read the following Telehealth Consent carefully. This section applies to patients who will be receiving any care through telehealth or telemedicine services.

What is Telehealth? Key examples of telehealth include:

- **Virtual Visits (Synchronous):** Live video or audio consultations with doctors, specialists, or mental health counselors to treat non-emergency conditions like colds, rashes, or anxiety.
- **Remote Patient Monitoring (RPM):** Using digital devices to track and send health data (e.g., blood pressure, blood sugar, heart rate) to providers, commonly used for managing diabetes, heart disease, or pregnancy.
- **Store-and-Forward (Asynchronous):** Sharing digital images or videos with specialists, such as a dermatologist reviewing a photo of a skin condition or a radiologist reviewing an X-ray.
- **Mobile Health (mHealth) Apps:** Smartphone apps for tracking health metrics, managing medications, and accessing nutritional care.
- **Wearable Sensors:** Devices that monitor vitals (e.g., heart rate, respiratory data) and alert caregivers to potential issues, such as a patient leaving their home.
- **Teletherapy/Counseling:** Online therapy sessions for mental health or behavioral health issues

Telehealth Benefits, Risks & Alternatives: Key Advantages of Telehealth

- **Improved Accessibility:** Patients in rural or remote areas can connect with specialists, eliminating travel time and costs.
- **Convenience and Efficiency:** Reduces time missed from work, eliminates waiting room times, and provides quick, on-demand care for minor issues.
- **Reduced Infection Spread:** Allows for safe evaluation of contagious conditions without exposing others in a waiting room.
- **Increased Access to Mental Health:** Enhanced continuity

Key Disadvantages of Telehealth

- **No Physical Exam:** Physicians cannot listen to lungs, touch, or perform hands-on tests, which may result in missed diagnoses.
- **Technological Barriers:** Requires reliable, high-speed internet and digital literacy, creating barriers for the elderly and lower-income populations.
- **Data Privacy/Security Concerns:** Risks of cyberattacks and, in some cases, less regulated platforms.
- **Interrupted Communication:** Technical issues (bad audio/video) and the lack of in-person, non-verbal cues can hinder communication.
- **Regulatory/Licensing Barriers:** Doctors may be restricted from practicing across state lines.

Telehealth Visit Expectations & Patient Responsibilities

40 **Do you have access to reliable internet or cellular connectivity for telehealth visits?** *

Yes, I have reliable internet / cellular access | No, I do not have reliable access | Sometimes / It depends

41 **What device(s) will you primarily use for telehealth visits?**

Smartphone (iOS/iPhone) | Smartphone (Android) | Tablet (iPad)

Tablet (Android) | Laptop Computer | Desktop Computer

I am Unsure

42 **Preferred Pharmacy for Telehealth Prescriptions**

Pharmacy

Telehealth Consent: Right to Withdraw: 24 hours written notice and sent to Plymouthmeetingpsych@gmail.com

43 **Telehealth Informed Consent Agreement** *

I Consent to Telehealth Services

I Do Not Consent to Telehealth Services (In-Person Visits Only)

SECTION 10: GENERAL TREATMENT CONSENT & AUTHORIZATION

Please read and acknowledge the following general treatment consent and authorizations required for your care.

Consent to Medical Treatment

44 **Do you consent to medical treatment by the providers and staff at this practice?** *

Yes, I Consent to Medical Treatment

I Have Questions Before I Consent

45 **Authorization for Release of Medical Records to Referring/Other Providers** *

Yes, I Authorize Release/Exchange of Records for Care Coordination

No, I Do Not Authorize Release of Records

I Want to Discuss This Further

46 **Healthcare Power of Attorney (if applicable)**

Answer

47 **Research & Quality Improvement Participation**

Yes, I consent to use of de-identified information for research/education

No, I do not consent to use of my information for research/education

SECTION 11: MINOR PATIENT INFORMATION (Complete if Patient is Under 18, skip to section 12

This section must be completed by a parent or legal guardian if the patient is under 18 years of age.
If you are a minor, your parents may be legally entitled to some information about your therapy. I will discuss with you and your parents what information is appropriate for them to receive and which issues are more appropriately kept confidential. In a divorce or
divorcing situation both parents must consent to treatment under Pennsylvania Law. In some cases parent's may make a request for documentation but this information can be denied based on 45-CFR 164.524(b)(2).
https://www.hhs.gov/hipaa/forprofessionals/faq/2046/under-what-circumstances-may-a-covered-entity/index.html. Edited and or changed 01/14/2021.

48 **Is this form being completed for a minor patient (under 18 years of age)?** *

- Yes, I am completing this for a minor
- No, the patient is 18 years of age or older

49 **Parent / Legal Guardian Information**

Parent/Guardian

50 **Legal Custody Status**

- Both Parents Share Custody (Married / Co-Parenting)
- Sole Legal Custody - Mother
- Sole Legal Custody - Father
- Shared Legal Custody (Divorced / Separated)
- Legal Guardian (Non-Parent)
- Foster Parent / Foster Care

Other Legal Arrangement

51 **Are there any court orders restricting who may authorize medical treatment?**

No, there are no court-ordered restrictions

Yes, there are court-ordered restrictions (documentation will be provided)

52 **List of Individuals Authorized to Bring Minor to Appointments**

Authorized Person's Full Name	Relationship to Minor	Phone Number	Authorization Level (Medical Decisions / Appointments Only)

SECTION 12: ELECTRONIC SIGNATURES & FINAL ACKNOWLEDGMENTS

Please review all sections of this form before providing your electronic signatures. Your signatures below are legally binding and confirm that you have read, understood, and agreed to all policies, consents, and authorizations contained in this document.

Summary of Agreements & Acknowledgments

53 **Confirm all information provided is accurate and complete ***

Yes, all information provided is accurate and complete to the best of my knowledge

54 **Date of Completion** *

MM/DD/YYYY

55 **Patient (or Legal Guardian) Electronic Signature** *

Sign here

56 **Printed Name of Patient or Legal Guardian** *

Long answer

57 **Relationship to Patient (if signing on behalf of patient)**

I am the Patient (Self)
Parent
Legal Guardian
Healthcare Power of Attorney
Spouse / Domestic Partner
Adult Child
Other Authorized Representative

58 **Witness Electronic Signature (Office Staff Use Only)**

Sign here

SMS PRIVACY POLICY

The privacy policy's sharing section must
explicitly state: "SMS Consent, and
phone numbers collected for SMS communication purposes will not be shared with
any third party or affiliates for marketing purposes."

Additional Considerations:

Please refrain from providing examples of
full privacy policies.

The privacy policy CANNOT be vague or
simple; it needs to take all aspects of use, collection, and sharing into
consideration.

A company can share information as long as
it DOES NOT share SMS consent or phone numbers for SMS by providing the
disclaimer; it will be compliant.

PDF files are generally acceptable for
privacy policies when they are easily accessible and include the required SMS
statement.

☐OPT-IN
LANGUAGE

"By checking this box, you agree to receive SMS messages from (company name)
related to (SMS Use Case). You may reply STOP to opt out at any time. Reply to
HELP to (phone number) for assistance. Messages and data rates may apply.
Message frequency will vary. Learn more on our privacy policy page and Terms
& Conditions.

59 **By signing you have read and agree**

Sign here