Joseph A. Maravi, LCSW-C

Patient Information Packet

Rev. Jan-16

Joseph A. Maravi, LCSW-C

9861 Broken Land Parkway
Suite 105
Columbia, MD 21046
301-490-0778 ext 3

Welcome to my practice. Please take a few minutes to read and complete the information in this packet including the new patient intake, consent to treat, and HIPAA notice.

Contact/Availability:
Please leave routine messages at my office telephone number. I can be reached on my cell at 443-831-9001 for clinical emergencies only. As I am often in session, I may not be immediately available so you should go to the nearest emergency room if I haven't responded quickly. My office hours are limited to evenings and Saturday mornings at present but I will be adding hours as needed in the future. **Fees/Payment:** My hourly fee is $140 for intake evaluations and $110 for regular sessions. Please pay at each session, cash/check preferred. If payment is being made through insurance, your responsibility will be the copay and any sessions that your insurance company does not pay. There is a $50 no show fee for any session that you do not cancel in advance. I you must cancel, please notify me at least 24 hours prior to your session. Last minute cancellations due to weather or medical emergencies are exceptions. But repeated last minute cancellations will be subject to $50 fee as well.

Insurance Authorization:
I authorize Joseph A. Maravi, LCSW-C to submit claims on my behalf to my insurance company. I also authorize to provide the information necessary for the insurance company to authorize these claims.

Print Full Name:_____ Signature:_____

Practice/Therapist History and Experience:

I have an extensive background treating adolescents and adults over the past 25 years. Utilizing multiple treatment modalities including individual, couples, family and group therapy, my approach is based on cognitive-behavioral and developmental models of psychotherapy. I have a strong interest and significant experience in problems related to mood, anxiety, crisis management, relationship issues, grief, ADHD, developmental/life transition issues, eating disorders, addiction, and schizophrenia. Geriatric issues have also been an area of need that I am currently addressing.

Beginning practice in a community mental health program at Sinai Hospital (5 years) and then Pathfinder Health Services (7 years) gave me a valuable experience with a varied population. Serving as an Associate Clinical Director at Pathfinder, I provided staff support and peer supervision in conjunction with my clinical work. I have gained additional crisis management experience providing emergency room consultations at Howard County General Hospital and inpatient psychosocial assessments at Sinai and Sheppard-Pratt Hospital. Currently, I have been with Psych Associates and in private practice since 2002 practicing in Baltimore and Howard County.

INFORMED CONSENT FOR TREATMENT

I have received the Joseph A. Maravi, LCSW-C Patient Information Packet, which includes information regarding access, fees, Patient Rights and Responsibilities and Privacy Practices. I accept these policies and practices.

I understand that behavioral health treatment offers no guarantees. By working with my therapist, doctor and/or counselor, I should get help with the problems and concerns I bring to Joseph A. Maravi, LCSW-C. However, I recognize that things may get worse. I understand that I will probably need to do homework-that is, try new ways of dealing with my problems-which I develop together with my therapist or counselor. If I do not do these things outside the office, I understand that the effectiveness of treatment will be limited.

I agree to cooperate fully with my therapist, doctor and/or counselor or to discuss with him or her any reasons why I cannot. I agree to ask any questions I have to clarify my therapeutic goals and how therapy is addressing them.

I understand that therapy will end when the problems and concerns I initially had are resolved. I also understand that I can terminate my therapy at any time I wish. I agree to notify my therapist, doctor or counselor of my intent to end therapy and to discuss the possible risks of premature termination of therapy.

I also understand that my therapist may end my treatment if we do not make progress, or if our relationship becomes too strained to continue working together. If I am no longer able to pay for services and treatment is to be terminated early, my therapist, will make suggestions to guide me in finding another provider of my choice. I will make every effort to follow the suggestions.

_____ Date:____/___/___
Patient/Guardian

_____ Date: ____/____/____
Witness

NEW PATIENT INTAKE FORM

PLEASE FILL IN COMPLETELY:

Patient Name: First_____ MI ____ Last_____

Date of Birth: ____/____/_____ Age: _____ Gender: (circle one) Male Female

Address_____City_____St_____Zip_____

Home Phone (____)_____Work Ph (___)_____Cell Ph_ (____)_____

Patient SS#_____ Occupation_____Highest level education_____

Ethnicity (circle one) Caucasian African American Asian Hispanic/Latino American Indian Other

Religion: _____

Personal/Family Physician_____ How did you hear about us?_____

Are you currently being treated by another mental/behavioral health professional? Yes No

Name of other provider(s) and reason for treatment:_____

Is this EAP? Y N **Workman's Comp?** Y N **Legal case?** Y N **For disability?** Y N

INSURANCE INFORMATION (COMPLETE IN ENTIRETY)

Insurance Company Name_____Phone_____

Policyholder's Name_____ SS#_____ Birthdate___/___/_____

Relationship to Patient (circle one): SELF SPOUSE PARENT If OTHER, specify:

Policyholder's Employer_____

Membership ID#_____Group #_____

Preauthorization number for this service: _____

Joseph A. Maravi, LCSW-C

CONSENT FOR TREATMENT OF A MINOR

As custodial parent, I authorize. Joseph A. Maravi, LCSW-C to provide evaluation and treatment of my minor child, _____.
(print name)

I also give permission for my child's treatment team to consult with clinicians and other primary care physicians associated with the care of my child. I understand that such consultation helps ensure quality care for my child.

_____ _____
Signature of parent or guardian Signature of witness

Date: _____/_____/_____

If the parents of this child are not living together, we will need a copy of the court document that explains custody arrangements. If there is joint custody, we will need both parents to sign the consent form **before the child can be seen**.

Second parent (if joint custody), please complete below:

_____ _____
Signature of parent or guardian Signature of witness

Date: _____/_____/_____

C:informedconsenttreatmentofminor.2010

Joseph A. Maravi, LCSW-C
9861 Broken Land Pkwy Suite 105
Columbia, MD 21046

HIPAA SIGNATURE FORM

By signing this form, I am agreeing that:

I have read and agree to the terms in the HIPAA notice.

_____ _____

Patient or Representative's Signature Date

_____

Print Name

_____

Relationship to Patient

Joseph A.Maravi, LCSW-C
9861 Broken Land Pkwy
Suite 105
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HIPAA Notice of Privacy Practices

Effective Date: 02/22/2015

Available on our website at www.simi-therapy.com, in the "HIPAA and Other Forms" section

If you have any questions about this notice, please contact Deborah Tucker at 805-583-3976 x 733. **Please note that this notice is required by Federal law, and the information it contains is mandated by that law.** If you have any questions about how your Protected Health Information (PHI) is used, please contact me.

NOTICE OF PRIVACY PRACTICES

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.

I am required by law to maintain the privacy and security of your protected health information ("PHI") and to provide you with this Notice of Privacy Practices ("Notice"). I must abide by the terms of this Notice, and I must notify you if a breach of your unsecured PHI occurs. I can change the terms of this Notice, and such changes will apply to all information I have about you. The new Notice will be available upon request, in my office, and on my website. The website will always have the most recent version.

Except for the specific purposes set forth below, I will use and disclose your PHI only with your written authorization ("Authorization"). It is your right to revoke such Authorization at any time by giving me written notice of your revocation.

Uses (Inside Practice) and Disclosures (Outside Practice) Relating to Treatment, Payment, or Health Care Operations Do Not Require Your Written Consent. I can use and disclose your PHI without your Authorization for the following reasons:

1. **For your treatment**. I can use and disclose your PHI to treat you, which may include disclosing your PHI to another health care professional. For example, if you are being treated by a physician or a psychiatrist, I can disclose your PHI to him or her to help coordinate your care, although my preference is for you to give me an Authorization to do so.

2. **To obtain payment for your treatment**. I can use and disclose your PHI to bill and collect payment for the treatment and services provided by me to you. For example, I might send your PHI to your insurance company to get paid for the health care services that I have provided to you, although my preference is for you to give me an Authorization to do so.

3. **For health care operations**. I can use and disclose your PHI for purposes of conducting health care operations pertaining to my practice, including contacting you when necessary. For example, I may need to disclose your PHI to my attorney to obtain advice about complying with applicable laws.

Certain Uses and Disclosures Require Your Authorization.

1. **Psychotherapy Notes**. I do not keep "psychotherapy notes" as that term is defined in 45 CFR § 164.501; rather, I keep a record of your treatment and you may request a copy of such record at any time, or you may request that I prepare a summary of your treatment. There may be reasonable, cost-based fees involved with copying the record or preparing the summary.

2. **Marketing Purposes**. As a psychotherapist, I will not use or disclose your PHI for marketing purposes. Marketing is defined as receiving financial remuneration for communicating about other businesses' health-related services or products to patients.

3. **Sale of PHI**. As a psychotherapist, I will not sell your PHI in the regular course of my business.

Certain Uses and Disclosures Do Not Require Your Authorization. Subject to certain limitations mandated by law, I can use and disclose your PHI without your Authorization for the following reasons:

1. When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.

2. For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone's health or safety.

3. For health oversight activities, including audits and investigations.

4. For judicial and administrative proceedings, including responding to a court or administrative order, although my preference is to obtain an Authorization from you before doing so.

5. For law enforcement purposes, including reporting crimes occurring on my premises.

6. To coroners or medical examiners, when such individuals are performing duties authorized by law.

7. For research purposes, including studying and comparing the mental health of patients who received one form of therapy versus those who received another form of therapy for the same condition.

8. Specialized government functions, including, ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counter-intelligence operations; or, helping to ensure the safety of those working within or housed in correctional institutions.

9. For workers' compensation purposes. Although my preference is to obtain an Authorization from you, I may provide your PHI in order to comply with workers' compensation laws.

10. Appointment reminders and health related benefits or services. I may use and disclose your PHI to contact you to remind you that you have an appointment with me. I may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that I offer.

Certain Uses and Disclosures Require You to Have the Opportunity to Object.

1. **Disclosures to family, friends, or others.** I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

YOUR RIGHTS YOUR REGARDING YOUR PHI

You have the following rights with respect to your PHI:

1. **The Right to Request Limits on Uses and Disclosures of Your PHI**. You have the right to ask me not to use or disclose certain PHI for treatment, payment, or health care operations purposes. I am not required to agree to your request, and I may say "no" if I believe it would affect your health care.

2. **The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full**. You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.

3. **The Right to Choose How I Send PHI to You**. You have the right to ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and I will agree to all reasonable requests.

4. **The Right to See and Get Copies of Your PHI**. Other than "psychotherapy notes," you have the right to get an electronic or paper copy of your medical record and other information that I have about you. I will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request, and I may charge a reasonable, cost based fee for doing so.

5. **The Right to Get a List of the Disclosures I Have Made**. You have the right to request a list of instances in which I have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided me with an Authorization. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable cost based fee for each additional request.

6. **The Right to Correct or Update Your PHI**. If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that I correct the existing information or add the missing information. I may say "no" to your request, but I will tell you why in writing within 60 days of receiving your request.

7. **The Right to Get a Paper or Electronic Copy of this Notice**. You have the right get a paper copy of this Notice, and you have the right to get a copy of this notice by e-mail. And, even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy of it.

HOW TO COMPLAIN ABOUT MY PRIVACY PRACTICES

If you think I may have violated your privacy rights, you may file a complaint with me, as the Privacy Officer for my practice. My address and telephone number are at the beginning of this document.

You can also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by:

1. Sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201;

2. Calling 1-877-696-6775; or,

3. Visiting www.hhs.gov/ocr/privacy/hipaa/complaints.

I will not retaliate against you if you file a complaint about my privacy practices.

EFFECTIVE DATE OF THIS NOTICE
This notice went into effect on April 14, 2013. The latest version was effective on the date noted at the beginning of this document