CAROLINE BUCKMAN, MSW, LCSW
245 S Limestone Lexington, KY 40508
859-224-8060

To my clients:

I am looking forward to our work together. I invite you to take an active part in guiding your care here by observing the following:

1. Our sessions are one hour long or longer as needed. It is helpful if you enter the session with your own goals in mind, expressed early on. Please park at the rear of the building and enter through the back door.

2. Please be prompt, as I will also attempt to be. There are occasional factors (handling an emergency, illness) which may cause me to be a bit late, but I will try to keep that to a minimum.

3. If you need to cancel, please do so at least 24 hours in advance (preferably 48 hours). My policy is to charge full fee if notice is not given. If I must cancel without affording you 24 hours notice, I will offer you an extra session, without fee. In the case of a true illness or emergency, this does not apply for either party.

4. Payment is expected at the time of service, unless other arrangements have been made.

5. This office is required by law to report child or adult abuse. Confidentiality does not apply in cases of life-threatening emergencies.

I understand and agree with the above.

Signed: ____

Date: ___________________

Patient name: ____
Sex: M / F
Patient address: ____
____
DOB :__________________ Marital status: __________________
Patient SS#: ____________________________
Custodial parent: ___________________________
(if patient is minor under the age of 18)
Custodial parent SS#: ___________________________
Patient phone: (Home) ___________________________
Patient Fax: ______________
(Cell) __________________________ May we contact you at all
(Work) ___________________________ these phone numbers? _______
Emergency contact:____________________________ Phone: ____________
Prior treatment? If yes, where?
____
Who referred you? ______________________________
Reason for being seen:
____
____
____

INSURANCE ISSUES AND LATE CANCELLATIONS

We are asking clients to assist in assuring that business issues flow smoothly. Because this office has set aside a full hour for your session, we are acknowledging that this one-on-one time is valuable. We cannot logistically fill this space with another client, without 24 (preferably 48) hours notice. Therefore, we ask that you give careful consideration to cancelling late or failing to remember when you are scheduled. You will be charged full fee for late cancellations or no shows.

Please acknowledge your understanding of these policies by signing below:

Signed: ______________________________________

Date: ______________________________

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that as part of my health care, Caroline Buckman, MSW, LCSW and affiliates originate and maintain health records. The health records describe my health history, symptoms, examination, and test results, diagnoses, treatment, and plans for the care or treatment. I understand that this information serves as:
-A basis for planning my care and treatment
-A means of communication among the many health professionals who contribute to my care.
-A source of information for applying my diagnosis and medical treatment information to my bill
-A means by which a third-party payer (i.e. insurance co.) can verify that services bills were actually provided
-And a tool for routine health care operations such as assessing quality and reviewing the competence of healthcare professionals Caroline Buckman, MSW, LCSW and affiliates' Notice of Privacy Practices gives a more complete description of how my health information may be used or disclosed. The notice also explains my rights regarding my personal health information, including the right to access my own records and the right to request restrictions as to how my health information is used or disclosed.

I understand it is my responsibility to notify Caroline Buckman, MSW, LCSW and affiliates regarding any restrictions concerning disclosure of health information regarding this or any subsequent visit.

I have been provided with a Notice of Privacy Practices and have been given the opportunity to review this information.

Signature : __________________________________

Date: _________________