New Patient Information Packet

Please fill out and bring with you at your appointment on: _____
at _____ with _____

Patient Information

First Name: _____ Middle Initial: _____ Gender: **M** **F**

Last Name: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: ( ) _____ SSN:_____

Work Phone: ( ) _____ Birth Date: _____

Cell Phone: ( )_____

Employed by:_____ Position:_____

Very Important: Which of these telephone numbers may we use if we need to contact you?_____ AND

In the event we need to contact you by telephone, who may we speak with or leave a message with, other than yourself? _____

EMERGENCY CONTACT INFO:_____

How were you referred to this office? _____

Patient & Family Information

Please check one: [ ] Single [ ] Married [ ] Other

Please check one: [ ] Employed [ ] Full-Time Student [ ] Part-Time Student

If Student, please list name of school & grade:_____

List Family Members/Significant Other Names & Ages: _____

_____

Party Responsible for Payment

**** This section must be filled out with parent information for all patients under the age of 18 ****

First Name: _____ Middle Initial: _____

Last Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: ( ) _____ Work Phone: ( ) _____

Signature of Responsible Party:_____

Insurance Information ***(Please bring proof of insurance to your appointment or you will be responsible for full payment at time of service. This section must be filled out completely or we cannot process your claim.)***

Patient's ID #: _____ Insurance Company: _____

Subscriber's SSN: _____ (Subscriber is the person who holds the insurance policy.)

Subscriber's Last Name: _____

Subscriber's First Name: _____ Middle Initial: _____

Patient Relationship to Subscriber: [ ] Self [ ] Spouse [ ] Child [ ] Other

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: ( ) _____ Work Phone: ( ) _____

Subscriber's Birth Date: _____ Subscriber's Employer:_____

I hereby authorize Chestnut Hill Counseling Associates - Portsmouth to release any billing information to "Party Responsible for Payment" (Parent or Guardian signature if patient is a minor)

Patient's Signature: _____ Date: _____

Primary Care Physician

Name of Family Physician: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Work Phone: ( ) _____ Date of last visit: _____

Referral Source Information (If a Professional)

Name _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Work Phone: ( ) _____

Are you currently being treated for any medical illness? If yes, please describe: _____

_____

_____

Have you ever been hospitalized for psychiatric reasons? If yes, please list dates and reasons: __

_____

_____

What medication(s) are you currently taking? _____

_____

_____

Please list any medication(s) that you have taken in the past five years: _____

_____

_____

Have you ever seen a Psychotherapist and/or a Psychiatrist before? If so, please list name(s) and date(s) of treatment: _____

_____

Has anyone in your family had emotional or psychiatric problems? If yes, please describe: ____

_____

_____

PROVIDER – PATIENT SERVICES AGREEEMENT

Welcome to my private practice. This document (the Agreement) contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a new federal law that provides new privacy protections and new patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) which you will receive with this agreement, for the use and disclosure of PHI for treatment, payment and health care operations. The Notice explains HIPAA and its application to your personal health information in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this information at the end of the first session. Although these documents are long and sometimes complex, it is very important that you read them carefully before our first session. We can discuss any questions you have about the procedures at that time. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on me unless I have already taken action in reliance on it; if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

Psychological and Medical Services

During the first session or two, I will help you identify your goals for therapy. Psychotherapy has both benefits and risks. While it has been shown to have benefits for people who invest in the process with commitment and realistic expectations, it also has risks that may include experiencing uncomfortable feelings or recalling unpleasant aspects of your history. These are common feelings when trying something new. Psychotherapy often leads to a significant reduction in feelings of distress, better relationships, and resolution of problems. However, we cannot guarantee any particular resolution to problems or a particular response to treatment.

Therapy involves a commitment of time, money, and energy. The office does its best to try to match you with a therapist who will be a good fit for you and can help you address your issues. If you have any questions about any procedures, it is important to discuss them with me whenever they arise. If your doubts persist or you are concerned that you and I are not suitably matched, an appropriate consultation with another professional in the practice may be beneficial.

In the case of marriage or family therapy, couples and/or parent/child relationships often improve significantly. However, we cannot guarantee that any or all relationships will improve or that the couple will not separate or divorce during or after treatment.

Office Hours and Emergency Contact

Office staff is available Monday through Friday from 9:00 a.m. to 5:00 p.m. There is an answering service when the office is closed should you need to reach me in an emergency. I cover my own emergencies unless I am away for an extended period of time, in which case a colleague within the practice covers for me. If you tell the answering service it is an emergency and ask them to call me, they will, and I will call you back as soon as I can. If you cannot wait for me to call you back, it may be possible to talk to someone else in the practice that is more readily available. If you are experiencing a serious emergency and cannot wait for a return call from me or another therapist in the practice, you should seek assistance at the local hospital emergency room.

Late Cancellation/Missed Appointments

Your appointment reserves my time. Once an appointment is scheduled, you will be expected to pay for the session if it is cancelled unless you provide ***24 business hours*** advance notice of cancellation**. (*For example, to cancel an appointment for 9AM on Monday, you would need to call before 9AM the previous Friday.)*** These charges cannot be billed to your insurance company. Please help me serve you better by keeping scheduled appointments and calling the office ***at least 24 business hours*** prior to your appointment time if you must cancel.

Pt. Signature_____

Confidentiality

A. General

In order for therapy to be successful, it is often necessary to safely reveal private, sensitive information about yourself in the course of treatment. Ethically and legally, all of us here are bound to keep all of this information strictly confidential. The law protects the privacy of all communications between a patient and a clinical provider. In most situations, I can only release information about your treatment to others if you sign a written Authorization form that

meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. Your signature on this Agreement provides consent for those activities, as follows:

I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The other professionals are also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together. I will note all consultations in your Clinical Record (which is called "PHI" in my Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information).

You should be aware that I practice with other mental health professionals and that I employ administrative staff. In most cases, I need to share protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing and quality assurance. All of the mental health professionals are bound by the same rules of confidentiality. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a clinical provider.

Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.
There are certain conditions under which confidentiality may be breached:

- If a patient threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her, or to contact family members or others who can help provide protection.
- If you disclose that a child or an elderly person is being sexually or physically abused, it must be reported to the proper authorities.
- If you are a danger to yourself or someone else, I must do whatever is necessary to protect you and/or the other person. The other person would have to be warned and the police notified.

In legal proceedings, the courts usually respect your rights to confidentiality in the therapeutic relationship, and I am ethically bound to protect that right when testifying in legal or administrative proceedings. However, a judge could court order me to testify in certain situations, such as a contested custody proceeding in a divorce and, under these circumstances, we must do so.

- If a government agency is requesting the information for health oversight activities, I may be required to provide it.
- If a patient files a lawsuit against me, I may disclose relevant information regarding the patient in order to defend myself.

It is our practice, whenever possible, to discuss any imminent breaches of confidentiality with you before taking any action and I will limit my disclosure to the minimum necessary.

It is our practice to consult with colleagues within the practice regarding clinical matters and on-call coverage. Full confidentiality, therefore, cannot be maintained within our group of clinicians, although the information shared is only the minimum necessary for the consultation or to insure effective clinical intervention. If you know someone within the practice in a nonprofessional capacity, please inform me right away. Your treatment will not be discussed with, or in the presence of, that person.

B. Professional Records and Patient Rights

The laws and standards of my profession require that I keep Protected Health Information about you in your Clinical Record. HIPAA provides you with several new or expanded rights with regard to your Clinical Records and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Records is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the Notice form, and my privacy policies and procedures. You may examine and/or receive a copy of your Clinical Record, if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them in my presence, or have them forwarded to another mental health professional so you can discuss the contents. In most circumstances, I am allowed to charge a copying fee of $15.00 for the first 30 pages or 50 cents per page, whichever is greater .

C. Minors

In cases of therapy with minors, parents or legal guardians have rights to information regarding treatment. However, in order for therapy to be effective, the child must have an assurance of confidentiality. Because of this, it is our policy to ask parents to agree that information will be shared only with the child's permission, except in situations where the child's safety is acutely at stake. Parents are encouraged to ask me about the therapy and together your child and I will talk with you about your concerns and will share information that is clinically optimal for the child to share as determined by the child and me.
Consent for treatment from **both parents** is required in order for treatment to occur. When a child turns 18, the control of his/her treatment and his/her treatment record reverts to the child. If this is a concern, please discuss it with me before starting treatment.

D. Couples and Families

When there is more than one person involved in treatment, such as in couples and family therapy, confidentiality is more complicated. In these cases, the unit is defined as the couple, or the family. Usually, and unless otherwise specified, information that is shared by a member of the unit within the context of that therapy cannot be considered confidential from the other parties involved in the therapy. To ask me to keep secrets from other members of the therapy can disrupt the trust necessary for an effective treatment. Also, to release information to third parties under such circumstances, all persons age 18 and over involved in treatment must consent in writing to that release.

E. Group Therapy

In group therapy, any and all information shared within the group sessions by any group member must be kept confidential consistent with the limits to confidentiality listed on pages 5 & 6 above.

F. Office Policies

All administrative and office staff are bound to confidentiality and cannot disclose any information. This becomes especially sensitive when relatives call the office requesting even simple information, such as an appointment time for their spouse. Even under these simplest of situations, the office personnel cannot acknowledge that they even know the person, nor can they disclose any information. If ongoing contact is to occur with a relative, regarding billing for example, then a release of information form can be signed, specifying the information that is permitted to be exchanged. All requests for records must be accompanied by a signed release of information. It is our office policy to keep records for 10 years from the date the record becomes inactive.

Insurance Reimbursement and Patient Balances

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. We accept assignment of insurance benefits from most insurance companies for your primary insurance only. However, we do require that deductibles and co-payments be paid in full at the time of service. The balance is your responsibility whether your insurance company pays us or not. Your insurance policy is a contract between you and your insurance company and we are not a party to that contract. If your insurance company has not paid your account in full within 45 days, the balance automatically becomes your responsibility. Please be aware that in some cases the services provided may be considered non-covered services by your insurance plan. Delinquent accounts must be paid in full before another session can be scheduled with your provider. Delinquent accounts may require further action.

You should carefully read the section in your insurance coverage booklet that describes mental health services. Your coverage, co-payments, and benefits could be quite different from your regular medical coverage. If your insurance plan includes a managed care component, you may be required to obtain preauthorization and your coverage may be limited. It is your responsibility to contact your insurance company to determine if preauthorization must be obtained by you prior to your treatment.
You should also be aware that most insurance agreements require you to authorize me to provide basic clinical information such as diagnosis and treatment plans. Occasionally an entire copied record is required. While it is our policy to release only the minimum necessary information required to activate your insurance benefits, you need to be aware that we cannot control its use by your insurance company. Any concerns you may have about confidentiality of managed care records should be directed to the managed care company.

Some insurance companies require that we send billing and other information electronically (e.g., by facsimile or e-mail). The confidentiality of such communications cannot be guaranteed. If you do not consent to electronic communications, please inform the office immediately, before beginning treatment, so that we can determine whether and how to proceed. Once information about your insurance coverage has been determined, it is important for you to

discuss with your clinical provider what can be accomplished with the benefits that are available, and what will happen should your benefits expire before you feel ready to end treatment. It is important to remember that you always have the right to pay for services yourself and not involve your health insurer at all.

F. Cost of Services

Licensed Psychologist

Initial Evaluation	$150.00
Individual Psychotherapy, 45 minutes	$125.00
Family/Couple Psychotherapy, 45 minutes	$135.00
Group Therapy (Cash Only)	$ 25.00
Appointment missed without 24 hours notice	$ 75.00

Licensed Independent Clinical Social Worker and Licensed Mental Health Counselor

Initial Evaluation	$125.00
Individual Psychotherapy, 45 minutes	$110.00
Family/Couple Psychotherapy, 45 minutes	$120.00
Appointment missed without 24 hours notice	$ 75.00

Board Certified Psychiatrist

Initial Evaluation	$250.00
E/M Low Complexity	$ 95.00
Psychotherapy with Med Check (45 Min.)	$200.00
Medication refills over the phone	$ 10.00
Appointment missed without 24 hours notice	Full fee

We bill at $200-$250 per hour for ancillary services such as preparing for and participating in legal matters relating to your treatment. A retainer, in advance, is required prior to undertaking such services. By signing this form you agree to pay for such services when you request them.

In Closing

It is important that you understand and are comfortable with the issues outlined above. Please bring up, in your first treatment session, any questions or concerns you might have.

Please Sign

I have read and accept the terms outlined on pages 4,5,6, & 7 above.

---------- ----------
Signature of patient or legal representative Date

---------- ----------
Signature of patient or legal representative Date

CONSENT TO RELEASE INFORMATION

I authorize my clinical provider to release and exchange medical information as necessary to my insurance carrier, my primary care physician, and a referring physician or therapist.

I understand I am responsible for contacting my insurance company for benefit coverage and preauthorization (if needed) prior to the day of treatment. I will provide this information to my clinical providers office (the Office) at the time of my first appointment. I will provide current information regarding my insurance throughout my course of treatment.

I understand that my insurance will be billed by the Office with the proper information provided.

I understand that this does not guarantee insurance payment to the clinical provider and that any outstanding balance is my responsibility.

I understand that regardless of insurance coverage, I must settle my account within sixty (60) days.

I further understand that I may revoke this authorization at any time should I desire by notifying this office in writing.

Name of Patient: _____

Signature of Patient or Legal Representative: _____

Date: _____

Signature of Therapist:_____ Date: _____

Receipt of HIPAA Notification and Bill of Rights_____Date:_____

PAYMENT POLICY FOR SERVICES RENDERED

NAME: _____

1. IF YOU HAVE INSURANCE WITH ONE OF THE FOLLOWING INSURANCE COMPANIES, please indicate below with your initials. These are the major insurance companies with whom we participate and have contracts. Please be aware that you are responsible for any deductibles, copayments, uncovered services or outstanding balances. **YOUR INSURANCE COMPANY REQUIRES US TO COLLECT COPAYMENTS AND COINSURANCE AT THE TIME OF SERVICE.** Payments should be made prior to your appointment when you check in or may be made directly to your provider prior to the start of your session. It is your responsibility to know what your plan covers as each employer chooses the plan to cover his/her employees. This is your insurance plan and we are not responsible for the changes your employer makes to your plan. If you are unclear about your insurance coverage, please speak with your employer or directly with your insurance carrier. If payment is not received by your insurance company within 45 days from the billing date, we will require full payment directly from you.

___	ANTHEM	___	CIGNA	___	HEALTH NET
___	TRICARE	___	EBPA/CBA	___	HARVARD PILGRIM
___	MEDICARE			___	UNITED HEALTHCARE
___	UNITED BEHAVIORAL HEALTH			___	VALUE OPTIONS
___	AETNA				

2. **IF YOU HAVE COVERAGE WITH AN INSURANCE COMPANY WHICH WE DO NOT HAVE A CONTRACT WITH**, we will help you with submitting a claim directly to your insurance company for reimbursement. **We do not accept Worker's Compensation Insurance.**

3. **IF YOU DO NOT HAVE INSURANCE**, you are responsible for payment of your bill, in full, at the time of your visit. We accept personal checks, cash, credit cards, and health savings cards.

4. **IF YOU ARE THE CUSTODIAL PARENT OF A MINOR**, by law you are ultimately responsible for payment of your child's medical bill, even if you are not the carrier of the insurance policy. Our agreement to provide services to your child is made with you. We are not party to any custodial/legal arrangements. Payments are due at time of service, and we will expect you to honor your responsibility whether you are with your child or are just dropping him/her off for the appointment.

5. **MISSED APPOINTMENTS/LATE CANCEL CHARGES** - Your appointment reserves the provider's time. Once an appointment is scheduled, you will be expected to pay for the session if it is cancelled unless you provide ***24 business hours*** advance notice of cancellation**. (*For example, to cancel an appointment for 9AM on Monday, you would need to call before 9AM the previous Friday.)*** These charges cannot be billed to your insurance company. Please help us serve you better by keeping scheduled appointments and calling the office ***at least 24 business hours*** prior to your appointment time if you must cancel.

6. **Please review and sign the next paragraph**:

"I understand that the services that are being provided to me will be directly billed to my insurance carrier for me. The insurance company should send payment directly to this office for payment. If payment is sent to me, I will forward the payment to the office immediately. If payment is not made within 45 days, I understand that it is my responsibility to follow up with my insurance company. I understand that this entire balance is at all times my responsibility."

"I understand and agree that I am responsible for the balance of my or my minor child's account for any professional services rendered. I certify that the above information is true and correct to the best of my knowledge. I will notify the office immediately of any changes in my insurance status and agree to pay all outstanding charges promptly."

_____	_____	_____
Patient or Guardian Signature	Date	Provider Signature

_____ (Pt. initials)