PSYCHIATRY AND FAMILY COUNSELING, LLP
Leominster Westborough Worcester

Patient Information Form

Last Name: First Name: Birth Date:

Street Address: Apartment:

City: State: Zip Code:

Home Telephone: Mobile Telephone: Age:
□preferred contact □preferred contact

Office Telephone: Email: Gender:
□preferred contact

Occupation: Social Security Number:

Employer: How did you hear about us? Please identify:

Primary Care Physician:

Primary Care Physician phone number:

□friend or family
□other physician
□other therapist
□presentation or workshop
□website
□directory listing
□article or publication
□other

Emergency Contact

Last Name: First Name: Relationship:

Home Telephone: Mobile Telephone:

Legal Guardian (if patient is a minor)

Last Name: First Name: Birth Date:

Home Telephone: Mobile Telephone: Age:
□preferred contact □preferred contact

Office Telephone: Email: Gender:
□preferred contact

Occupation: Social Security Number:

Child's School: _____ Grade:_____ Teacher:_____

Any Special Education Services? Y N If yes, describe:_____

If child has been retained a grade, which grade? _____

Child's Physician: _____ Phone:_____

Any medical conditions or allergies? _____ Who referred you?_____

Please list any medications and doses your child takes:_____

Please list child's parents/or step-parents:

Name: Age: Relationship Address(if different from child) Home #: Work #: Occupation:

_____

_____

_____

_____

Please list child's siblings and/or step-siblings:

Name Relationship Age

_____

_____

_____

_____

Are any of the children in the family adopted? _____

_____

If your child has seen other therapists in the past,
Please list names of professionals and approximate dates:

_____

_____

Are there any important or pending legal problems, such as any difficulties with the law, custody problems, etc.? Y N If so, please describe these problems: _____

_____

_____

Has the patient ever been on any psychiatric medication? Y N If yes, please list medication(s) and dose

_____

Which medication is currently being taken and at what dose: _____

_____

Has the potential patient ever been hospitalized for psychiatric reasons? Y N If yes, when was the last hospitalization? _____

Please briefly describe the nature of the problem which you are seeking services for: _____

_____

Insurance Information

Insured's last name: _____ Insured's first name: _____ Birth date: _____

Insurance company: _____ Phone: _____

Address: _____ State: _____ Zip code: _____

Subscriber ID number: _____ Group number: _____ copay amount: _____

I, as the insured individual named above, give Psychiatry and Family Counseling, LLP permission to file my information and request payment. I understand that I am responsible for all charges not paid by the insurance or managed care company.

_____

Signature: _____ Date: _____

INTRODUCTION

Welcome to ***Psychiatry and Family Counseling, LLP***. Our website contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and 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 we provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that we obtain your signature acknowledging that we have provided you with this information at the end of your 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.

PSYCHIATRY AND FAMILY COUNSELING, LLP

Office Policy

Please familiarize yourself with our office policies. If you have any questions, please call our office or your doctor.

Insurance

1. Patients are responsible for being aware of current insurance coverage. This includes the details of:
   - Out of network benefits
   - Deductible and/or "out-of-pocket"
   - Need for pre-certification
   - Current coverage and copayment
   - Maximum annual visits
   - Current visits remaining
   - Any changes in coverage

2. If you have exceeded your benefits covered you are responsible for the **full payment** for any uncovered sessions.

3. Your mental health coverage may be "carved out" to other managed care companies although this is rare, we may be considered **out-of-network** with those companies.

4. Please note that your insurance may place limits on the number of visits allowed per calendar year. This may not be sufficient to cover the clinically appropriate level of care determined by your doctor.

Medications

1. To ensure quality care**, regular follow up** with routine office visits is necessary for prescriptions to be provided.

2. Please inform your physician about needed refills at least 3 business days before your medication runs out. Set aside an emergency reserve of 3 to 5 days of each prescription.

Cancellations

1. Because your appointment time has been reserved for you, **you will be charged for cancellations with less than 48 hours (2 business days)notice.** For example, if your appointment is scheduled on a Monday or following a long weekend, please call on the preceding Friday.

2. **Charges for missed appointments are not covered by your insurance and are due and payable prior to any further appointments.** Please note that such charges include the amount normally covered by the insurance company **in addition to the copay amount.**

Telephone Calls

1. Please leave your full name and phone number with your message. Please leave the best time of day to call.

Payment

1. Payment is expected at the time of appointment. We accept cash or check.
2. Requests for written reports or records may incur additional charges.
3. There is a $50 charge for returned checks

Office Policy Patient Acknowledgement

Patient Name: _____ Birth Date: _____

I have received a copy of the office policy of Psychiatry and Family Counseling, LLP and agree to the terms within.

Signature: Date:

Relationship to patient (if signed by authorized representative)
□ Parent □Legal Guardian □other

Psychiatry and Family Counseling, LLP
Leominster Westborough Worcester

Notice of HIPAA 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 if carefully

I. Our Responsibility

The confidentiality of your personal health information is very important to us. Your health information includes records that we create and obtain when we provide you care. it also includes bills, insurance claims, or other payment information that we maintain related to your care.

This Notice describes how we handle your health information and your rights regarding this information. Generally speaking, we are required to maintain the privacy of your health information as required by law; provide you with this Notice of our duties and privacy practices regarding the health information about you that we collect and maintain; and follow the terms of our Notice currently in effect.

II. Contact Information

After reviewing this Notice, if you need further information or want to contact us for any reason regarding the handling of your health information please direct any communications to your therapist.

III. Uses and Disclosures of Information

Under federal law, we are permitted to use and disclose personal health information without authorization for treatment, payment, and health care operations. Participants in this organized health care arrangement also share health information with each other, as necessary to carry out treatment, payment, or health care operations We may share the minimum amount of personal health information necessary for business associates performing services on our behalf.

IV. Other Uses and Disclosures

- As required by the Food & Drug Administration
- ~ Health oversight activities
- ~ In response to legal proceedings
- ~ Other covered entities' payment activities
- ~ Other covered entities' healthcare operations activities to the extent permitted under HIPAA
- ~ Other healthcare providers' treatment activities
- ~ Other public health activities
- ~ To prevent a serious threat to public health or safety
- ~ To workers' compensation or similar programs for processing of claims
- ~ Uses and disclosures required by law
- ~ Uses and disclosures required by law for unempancipated minors
- ~ Uses and disclosures in domestic violence or neglect situations

V. Any Other Use or Disclosure

Before using or disclosing your personal health information for any other purpose not identified above, we will obtain your written authorization. Unless action has already been taken in compliance with the authorization by submitting your written request to us.

VI. Your Health Information Rights

~ Request that we restrict certain uses and disclosures of your health information; we are not, however, required to agree to a requested restriction.

~ Request that we communicate with you by alternative means, such as making records available for pick-up

- As required during an investigation by law enforcement agencies

or mailing them to you at an alternative address, such as a P.O. Box. We will accommodate reasonable requests for such confidential communications.

~ Request to review, or to receive a copy of, the health information about you that is maintained in our files and the files of our business associates. We reserve the right to charge a fee for the costs of copying, mailing or other supplies associated with your request. If we are unable to satisfy your request, we will tell you in writing the reason for the denial and your right, if any, to request a review of the decision.

~ Request that we amend the health information about you that is maintained in our files and the files of our business associates. Your request must explain why you believe our records require amendment. If we are unable to satisfy your request, we will tell you in writing the reason for the denial and tell you how you may contest the decision, including your right to submit a statement disagreeing with the decision. This statement will be added to your records.

~ Request a list of our disclosures of your health information. This list, known as an "accounting" of disclosures, will not include certain disclosures, such as those made for treatment, payment, or health care operations. We will provide you the accounting free of charge, however, if you request more than one accounting in any 12 month period, we may impose a reasonable, cost-based fee for any subsequent request. Your request should indicate the period of time in which you are interested. We will be unable to provide you an accounting for any disclosures made before

~ Request a paper copy of this Notice.

In order to exercise any of your rights described above, you must submit a written request to our office. If you have questions about your rights, please speak with our contact person, available by phone or email during normal office hours.

VII. To Request Information or File a complaint

If you believe your privacy rights have been violated, you may file a written complaint by mailing it or delivering it to our contact person. You may complain to the Secretary of Health and Human Services (HHS) by writing to Office for Civil Rights, U.S. Dept Of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington D.C. 20201; by calling 1-(800)368-1019; or by sending an email to OCRprivacy@hhs.gov. We cannot, and will not, make you waive your right to file a complaint as a condition of receiving care from us, or penalize you for filing a complaint

VIII. Revisions to this Notice

We reserve the right to amend the terms of this Notice. If this Notice is revised, the amended terms shall apply to all health information that we maintain, including information about you collected or obtained before the effective date of the revised Notice. If the revisions reflect a material change to the use and disclosure of your information, your rights regarding such information, our legal duties, or other privacy practices described in the Notice, we will promptly distribute the revised Notice, post it in the waiting area of our offices, make copies available to our patients and others, and post it on our website.

Privacy Practice Patient Acknowledgement

Patient Name:_____ Birth Date:_____

I acknowledge that I have received a copy of the Notice of Privacy Practices of Psychiatry and Family Counseling. The Notice provides in detail the uses and disclosures of my protected health information that

may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

_____

Signature: Date:

_____

Relationship to patient (if signed by authorized representative)

□parent □legal guardian □other

Psychopharmacology (medication) with Children and Adolescents

At times, the use of medication is helpful with children and teenagers with certain emotional and psychological problems. The evaluation process will determine who would benefit from this approach. When we recommend medication, it is always done in combination with psychotherapy. Our psychiatrist and clinical nurse specialists are specifically trained in child and adolescent psychopharmacology. Some of the areas where medication may be indicated include: Attention Deficit Disorders, Depression, Anxiety Disorders, including Obsessive Compulsive Disorder and Bipolar Disorder. This approach is always done with careful consideration and clear explanations of benefits and risks.