Welcome,
We appreciate that your decision to seek consultation with us is likely accompanied by some relief as well as some nervousness, and we hope you will find your experience with us to be both positive and productive. By asking you to fill out these materials now, before your first appointment, we shall be able to put your consultation time to the most efficient, best possible use. If you have any questions about these materials, please ask your doctor, therapist or nurse practitioner.

Michael F. Jacques, Ph.D., Director

Confidentiality & Protected Health Information

Communication between a patient and his or her psychologist, psychiatrist, social worker, clinical nurse specialist or counselor is confidential, and we are bound by law and ethics to safeguard your Protected Health Information (PHI).

- We will obtain your authorization before using or disclosing your PHI, other than as described in this notice.
- The professionals involved in your care may seek consultation internally without separate authorizations to do so.
- The practice may use and disclose the minimum information necessary for treatment, billing, and healthcare operations involving your care. This may include communication and coordination with your primary care doctor or other healthcare professionals, all of whom are also bound to protect the confidentiality of your PHI.
- If you are using health insurance to pay for your care, you have already given your permission to the insurance company to access information necessary to process claims for payment, oversee services provided and perform quality assurance functions.
- If you are paying for your care entirely out-of-pocket, you have the right to restrict disclosure of PHI to a health plan. This does not apply to out-of-pocket payment of health insurance deductibles.
- You will be notified if there is ever a breach of your PHI.

In the case of minor children, Massachusetts law allows parents the right to examine treatment records. Though you will be asked to be involved in and informed about your child's progress, release of specific communications often can jeopardize a child or adolescent's willingness to be forthcoming with her/his doctor or therapist and as such may become an impediment to the child's benefitting from his or her treatment. In order to both respect the confidential nature of your child's information and facilitate the building of trust, your child's doctor or therapist will ask you to agree to certain limits on the information that will be shared with you. Of course, if there are ever any concerns about potential dangerousness, you will be notified immediately.

Mental health professionals are required by law to break confidentiality under the following circumstances:

1. If an individual intends to take harmful or dangerous action against another individual, we must warn the person and/or family of the person who is likely to suffer the results of the harmful behavior, as well as the local authorities, in order to protect the individual and any potential victim(s).
2. If an individual poses a danger to himself or herself, we must disclose information necessary to keep the individual safe and to facilitate appropriate treatment.
3. Suspicion of child abuse or neglect.
4. Information regarding sexual contact between children under the age of 16.
5. Suspicion of the abuse of elders or handicapped persons.
6. In response to a court order by a judge of appropriate jurisdiction.
7. If a patient introduces his or her mental condition as an element of claim or defense in a legal proceeding.
8. Court investigations into child custody or adoption.
9. Workers' compensation claims.

Please bear in mind that should the occasion ever arise, every effort will be made, as clinically appropriate, to discuss and/or resolve any issues before such a breach of confidentiality takes place.

Record Requests require completion of our Authorize to Release of Protected Health Information form

- Forms are available on our website: http://psycare.info/our-forms/ or from our Patient Records Office: x128
- Charges for reproduction of records apply. Information is available from our Patient Records Office: x128

Consent to Evaluation & Treatment: ***Children***

Treatment can promise great benefit and also comes with some risks. Risks can include experiencing uncomfortable levels of emotion such as sadness, guilt, anxiety or anger; and recalling and discussing unpleasant life experiences can be distressing. Prescribed medications can produce unwanted side effects in addition to the desired effects. The professionals working with you and your child will discuss with you the benefits, risks and side effects of the treatments under consideration in your child's particular case. Though there are no guarantees, the treatments we offer have been shown to benefit people and lead to reduction of symptoms, as well as improved relationships and overall ability to meet and more successfully deal with life's challenges.

In the case of minor children, parents must provide consent for treatment. In the case of shared or joint, legal custody of a child by divorced parents, the consent of one parent is required to proceed, however the other parent must not state a clear objection. If you are the parent who is bringing your child in for appointments, you may be asked for the name, address and telephone number of his or her other parent. As a routine matter, both parents will be invited to participate in your child's treatment. The exact form and frequency of such contacts will be determined on the basis of need as assessed on a case-by-case basis by your child's doctor or therapist. When one parent objects, treatment cannot proceed. In order for treatment to proceed, parents must resolve the matter between them, or refer the matter to the court for resolution.

This consent will remain in effect through completion of your child's care at Psychological Care Associates. You have the right to revoke your consent to treatment at any time. Should you choose to do so, we ask that you do so in writing. Notice of revocation of consent will be considered effective on the date your child's doctor or therapist receives your revocation. Revocation of consent will necessarily result in termination of treatment.

Patient Name (**Printed**)	Date of Birth
Parent or Guardian Name (**Printed**)	Relationship to Patient
Parent or Guardian Signature	Today's Date

Consent to Evaluation & Treatment: ***Adults***

Your treatment can promise great benefit and also comes with some risks. Risks can include experiencing uncomfortable levels of emotion such as sadness, guilt, anxiety or anger; and recalling and discussing unpleasant life experiences can be distressing. Prescribed medications can produce unwanted side effects in addition to the desired effects. The professionals working with you will discuss with you the benefits, risks and side effects of the treatments under consideration in your particular case. Though there are no guarantees, the treatments we offer have been shown to benefit people and lead to reduction of symptoms, as well as improved relationships and overall ability to meet and more successfully deal with life's challenges.

This consent will remain in effect through completion of your care at Psychological Care Associates. You have the right to revoke your consent to treatment at any time. Should you choose to do so, we ask that you do so in writing. Notice of revocation of consent will be considered effective on the date your doctor or therapist receives your revocation. Revocation of consent will necessarily result in termination of treatment.

Patient Name (**Printed**)	Date of Birth
Patient's Signature	Today's Date

Appointments: Our time, like yours, is a limited resource. We work hard to stick to our schedules so that you and others in need of our time can be seen. We appreciate your efforts at respecting our time together as well.

Cancellation of a scheduled appointment requires **a minimum** advance notice **of 24 hours.**
The missed or late-cancelled appointments is $80, cannot be billed to insurance, & must be paid your next appointment.

Payment: You are responsible for all deductibles, co-payments and balances that are not covered by your health plan.

1. If you are registering a minor or dependent individual, you are accepting responsibility for his/her bills.
2. We will not bill any other party for services rendered or charges incurred.
3. All payments are due at the beginning of each visit.
    a. We accept Cash, VISA & MasterCard, Personal Checks payable to: Psychological Care Associates, p.c.
    b. There is a $30 charge for all returned checks or ACH deposits.

Insurance: To bill your insurance company, we need timely, accurate information from you.

1. To avoid any lapse in your care being covered, contact our Office Manager (x112) immediately if you become aware of any problems or if anything changes concerning your insurance
2. If your health plan denies payment, you will be responsible for all charges if the denial is due to:
    a. A lapse, termination or limitation of your coverage
    b. Lack of prior authorization for which needed information was not provided in time
    c. Your failure to respond to your insurer's request for information from you

Services NOT covered by health insurance:

1. **Any service provided outside of face-to-face sessions**.
    Self-pay services are charged based on five (5) minute increments
    Examples include:
    - Phone calls or email between sessions (except for emergencies or scheduling purposes) with patients, family members, school personnel, attorneys or others on behalf of the patient
    - Report or letter writing for purposes beyond documentation of your care such as completion of disability, FMLA or other forms or applications
    - Review of records
    - Attendance at meetings (including travel time)
2. **Your insurance company places limitations** on which health care services are covered, and to what extent.
    Examples include:
    - Services provided for educational or vocational purposes (neuropsychological or educational testing)
    - Services deemed not medically necessary
3. **If you become involved in a legal proceeding** that requires our participation, you will be expected to pay for the involved provider's time, even if called to testify by another party.
    - We charge an increased hourly rate for work involving legal matters to cover costs, including but not limited to time for preparation, communications, travel, attendance, and legal consultation we may need to engage. (Contact our Office Manager at x112 for rates)
    - A retainer of 5 hours of service is required in advance, renewable as needed.

Our fees are available from our Office Manager at x 112, and are subject to change without notice.

Failure to pay bills may interfere with the scheduling of future appointments and may ultimately result in the termination of services and/or referral of the debt to a collection agency.

Patient Name:_____ Date of Birth:_____

Patient *Signature*_____ Date:_____
(Parent/guardian if a dependent)

Credit Card on File Agreement

Credit Card information is stored in the database of the credit card processing company, Trans Engen and not in PCA's Electronic Medical Record System. An inactivated card can be reactivated at a later date. If a card is removed, it is completely erased from the Trans Engen database. Once removed, to use a card again requires the completion of a new Card on File Agreement.

If you would like to keep your credit card on file for your convenience, please complete the information below and present it in person at your next appointment. Your card can only be placed on file at the time of a scheduled appointment.

I hereby authorize Psychological Care Associates, p.c. (PCA) to keep my credit or debit card information on file for payment of my charges. Payment by credit or debit card will only occur with the cardholder's agreement for each instance. Charges will not occur automatically. I acknowledge that the origination of ACH or credit card transactions to my account must comply with the provisions of U.S. law.

If my bank or credit card information listed below changes for any reason, I will notify PCA. This authorization will remain in effect until the end date listed or until PCA has received written notification from me of its termination. In the event of a returned ACH, my account will be charged a $30 service fee for each occurrence.

Patient Name:_____ Date of Birth:_____

Cardholder Name (as it appears on the card):_____

Cardholder Address:_____

City:_____State:_____Zip:_____Phone:_____

Card Type: MasterCard Visa

Card # (Last 4 Digits only): ____ ____ ____ ____ Card Expiration Date:_____/_____/_____

Cardholder Signature:_____Date:_____/_____/_____

Authorization to communicate via E-mail

I do hereby authorize Psychological Care Associates, p.c. (PCA) to communicate by e-mail with me and/or the persons named below, for my own convenience, and without restriction or further qualification.

Limits: I understand that e-mail is not a secure means of communication and that its use could conceivably result in an unintended release of my PHI.

Liability: I hereby indemnify and hold harmless, absolve and release PCA and its employees, agents, officers, directors and contractors from any and all responsibility for any breach of confidentiality or privacy that may occur, directly, indirectly or inadvertently through the use of e-mail, and I hereby waive any and all claims for liability which I might otherwise have for direct or indirect harm or damages caused by PCA's use of e-mail.

Term: This authorization will remain in effect, unless revoked, until the completion of my care at PCA.

Revocation: I understand that I have the right to revoke this authorization at any time and will submit such revocation in writing.

Limitations:
1. E-mail should not be used for discussion of sensitive or private information.
2. E-mail cannot be used for urgent/emergency matters; nor can it substitute for meeting in person.
3. Time-sensitive communication must be handled by telephone as the time frame within which e-mail will be read by the intended recipient is unpredictable.
4. E-mail (other than for scheduling) is billable at our hourly rate and cannot be billed to insurance.

My e-mail address: _____

I further authorize Psychological Care Associates, p.c. to use e-mail to communicate about me or my dependent, and to release protected health information, including opinions, to the following person(s):

Name	Relationship	e-mail address
1.		
2.		
3.		

_____ _____
Patient Name (Printed) Date of Birth

_____ _____
Patient *Signature* (Parent or guardian if a minor or dependent) Today's Date

_____ _____
Parent / Guardian Name (Printed) Relationship to Patient

MEDICAL HISTORY

Name_____Date of Birth_____Age___Today's Date____/____/____

Gender: M F Marital Status: S M D W # Years Completed in School:_____Occupation:_____

I Live With:_____Primary Care Physician:_____Date of Last Physical Exam___/____/___

Emergency contact: _____Relationship:_____Tel:_____

Other Health Care Providers Involved with me:_____

Conditions/Illnesses I am being treated for: _____

Medications I take:_____Prescribed by:_____

 # days/ week I use: Sleeping pills ( ) Laxatives ( ) Sedatives ( ) Tranquilizers ( ) Appetite Suppressants ( )

Other medicines I take, including vitamins, supplements, O.T.C. medicines, herbal remedies, or medicine Rx'd for someone else:

_____

Alcohol: _____per day, _____days per week. **Tobacco:** _____packs per day

Recreational drugs:_____per day, _____days per week **Caffeine**: _____drinks per day

Allergies: □ None □ List: _____

Have you ever been exposed to (circle): TB Hepatitis AIDS Toxins Sexually Transmitted Disease(s)

YOUR FAMILY MEDICAL HISTORY: Has anyone ever been treated for any of the following?

Condition	Relation to you	Condition	Relation to you	Condition	Relation to you
ADD/ADHD		Depression		Schizophrenia	
Anxiety		BiPolar Disorder		Dementia	
OCD		Suicide or Attempted		Psychiatric Hospitalization:	
Eating Disorder		Alcohol/Drug Problem			

YOUR MEDICAL HISTORY: **Circle** all that apply TO YOU, past or present:

Acne	Cataracts	Gallstones	Lupus	Sexual Problems
Anxiety	Coordination	Hallucinations	Memory Problems	Sinus Trouble
Angina	Concentration	Head Injury	Migraines	Sleeping Problems
Anemia	Chronic Fatigue	Headaches	Mood Swings	Stroke
Allergies	Chest Pressure	Hearing Voices	Multiple Sclerosis	Swollen Ankles
Appetite Change	Depression	Heart Attack	"Nerves"	Thyroid Problems
Arthritis	Decreased Libido	Heart Burn	Nose Bleeds	Thoughts of:
Asthma	Diabetes	Hemorrhoids	Numb/Tingling	- Harming Self
Back Pain	Diarrhea	Hernia	Feet	- Harming Others
Blackouts	Difficulty Hearing	Hot Flashes	Number of	Tinnitus (Ears
Blood Clots	Difficulty Smelling	Hypertension	Pregnancies:	Ringing)
Bronchitis	Dizziness	Insomnia	#:____	Tremors
Bruise Easily	Earaches	Irregular Heart	Osteoporosis	Ulcers
Bursitis	Easily Hot/Cold	Beats	Pain	Urinating
Cancer	Emphysema	Irregular Periods	Palpitations	Problems
Chest Pain	Epilepsy	Irritable Bowel	Pancreatitis	Vision Problems
Colitis	Erectile	Syndrome	Rashes	Vomiting
Cough	Dysfunction	Joint/Muscle Pain	Rheumatic Fever	Wake to Urinate
Crohn's Disease	Fainting	Kidney Stones	Rheumatoid	Weight Gain/Loss
Constipation	Fatigue	Lethargy	Arthritis	
	Fibromyalgia	Lumps in the Neck	Seizures	

Exercise? How:_____How Often:_____ **Sleep:**____hrs/night **Awake Rested**: Y N **Like work/school?** Y N
Do you have regular bowel movements Y N **Use contraception?** Y N Form:_____**Have guns/other weapons at home** Y N
Vacations: # weeks/yr:_____**Hobbies/Activities?**_____
 # Hours per day: Watching TV:_____ **Online/Video Games:**_____ **Reading:**_____ **Other**:_____