

## 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 practice may use and disclose the minimum information necessary for treatment, billing, and healthcare operations involving your care. Health care professionals involved in your care may share information without specific authorizations to do so, including 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

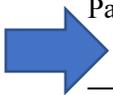
\_\_\_\_\_  
Patient Name (**Printed**)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Patient's *Signature*

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Today's Date

(Parent/guardian if a dependent)



# Psychological Care Associates

A Division of Child & Family Psychological Services, PLLC

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## 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 ( <b>Printed</b> )	Date of Birth
_____	_____
Parent or Guardian Name ( <b>Printed</b> )	Relationship to Patient
_____	_____/_____/_____
Parent or Guardian <i>Signature</i>	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 ( <b>Printed</b> )	Date of Birth
_____	_____/_____/_____
Patient's <i>Signature</i>	Today's Date

# Psychological Care Associates

A Division of Child & Family Psychological Services, PLLC

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**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 fee for a missed or late-cancelled appointment is \$80**, cannot be billed to insurance, & must be paid by 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 Receptionist or 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.

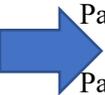
- We charge an increased hourly rate for work involving legal matters to cover costs, including but not limited to time for preparation, communications, travel, attendance, and legal consultation we may need to engage. (Contact our Office Manager at x112 for rates)
- A retainer of 5 hours of service 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)

## Patient Billing and Services Notice

Our goal is to provide you with the best clinical care possible. We are also committed to helping our patients be informed consumers of behavioral health care services. Please review the following information on billing procedures, which is also outlined in your registration packet. We hope you will find this helpful in better understanding your healthcare experience.

### Services, CPT Codes, and Fees:

All healthcare providers are required to bill for services rendered by using Current Procedural Terminology (CPT) codes established by the American Medical Association. This system requires clinicians to frequently use multiple codes for one service and/or change the coding after the service is completed in order to accurately reflect the service provided, and may depend on several factors, including time spent, diagnosis, focus of treatment, and complexity.

This coding system is understandably confusing for patients, both due to the multiple codes that can be used for the session and fee adjustments that often occur *after* services have taken place. We do our best to **estimate** the cost of services accurately before appointments, to minimize the need for modifications later. However, service code adjustments commonly change after the appointment. **When service codes are adjusted, it can result in either additional or decreased fees, if you have a deductible or coinsurance. The exact amount cannot be guaranteed in advance of your visit. Patients with flat copayments do not incur additional copays when service codes are adjusted.**

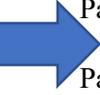
### “Add on” Codes:

Behavioral health appointments both for therapy and for medication management (psychopharmacology) commonly include a primary and secondary code, and sometimes a third code, for the same appointment based on situational factors of the session. Please note that this is not representative of “double billing” but rather reflects our compliance with federal coding rules and regulations.

**Thank you for entrusting us with your behavioral health care. Please also know that we approach billing practices with the same level of integrity as our clinical work.**

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

 Patient *Signature* \_\_\_\_\_

Date: \_\_\_\_\_

(Parent/guardian if a dependent)

## ***Psychological Care Associates***

*A Division of Child & Family Psychological Services, PLLC*

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**After Hours Contact and Emergency Procedures:** In life threatening emergencies, you should call 911 or proceed to the closest emergency room or inpatient mental health facility. Although it is rare, events may occur for which you need urgent unscheduled assistance from your clinician. Follow the prompts in the extension menu to have your clinician urgent paged. Due to their work schedules, your clinician is generally not immediately available by telephone and do not answer the phone when they are with a patient. You may leave a voice message for your clinician and they will make every effort to return your call within 24 hours, except for weekends, holidays, and vacations.

**Termination of Provider-Patient Relationship:** We reserve the right to terminate the Provider-Patient relationship if we determine that the continued provision of services is not in the best interest of the Provider or yourself. Circumstances that may lead to the termination of services include, but are not limited to, (i) missing multiple appointments, (ii) failing to pay for services provided when due, (iii) threatening, harassing or otherwise creating a hostile environment for providers, staff or other patients or guests, (iv) failure to adhere to your treatment plan, and (v) use of illegal drugs or abuse of prescriptions.

**Medications:** You may be prescribed medications during your course of treatment. Coverage for specific pharmaceuticals varies significantly for each insurance plan. In some instances, your insurance plan may require prior authorization which generally takes 3-7 business days but may take longer. You are expected to adhere to your provider's guidelines for obtaining and refilling medications, which may include the following:

- You must have a future appointment scheduled before a refill request will be considered.
- Go to FORMS on our website: [www.psycare.info](http://www.psycare.info) and complete a Refill Request Form **OR**
- Call the Refill Line: 781-646-0500 x385
- Please provide: full name, date of birth, name of medications, and name and location of pharmacy.
- Refill requests are reviewed weekdays at 10am and 3pm.
- **Refills commonly take at least 2 business days before your pharmacy dispenses them.**
- **Calling your Doctor of Nurse Practitioner directly will usually delay getting your refill.**
- If you keep your scheduled appointments, you are not likely to ever need to request a refill.

A copy of these guidelines is available at the front desk or from your prescriber.

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

 Patient *Signature* \_\_\_\_\_

Date: \_\_\_\_\_

(Parent/guardian if a dependent)

## **Authorization to communicate via E-mail**

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

<u>Name</u>	<u>Relationship</u>	<u>e-mail address</u>
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

**Psychological Care Associates**  
*A Division of Child & Family Psychological Services, PLLC*

**MEDICAL HISTORY**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Today's Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Gender: M F N 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?

<u>Condition</u>	<u>Relation to you</u>	<u>Condition</u>	<u>Relation to you</u>	<u>Condition</u>	<u>Relation to you</u>
ADD/ADHD	_____	Depression	_____	Schizophrenia	_____
Anxiety	_____	Bipolar Disorder	_____	Dementia	_____
OCD	_____	Attempted Suicide	_____	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 Feet     | - Harming Self          |
| Back Pain       | Diarrhea             | Hernia                   | Number of Pregnancies: | - Harming Others        |
| Blackouts       | Difficulty Hearing   | Hot Flashes              | #: _____               | Tinnitus (Ears Ringing) |
| Blood Clots     | Difficulty Smelling  | Hypertension             | Osteoporosis           | Tremors                 |
| Bronchitis      | Dizziness            | Insomnia                 | Pain                   | Ulcers                  |
| Bruise Easily   | Earaches             | Irregular Heart Beats    | Palpitations           | Urinating Problems      |
| Bursitis        | Easily Hot/Cold      | Irregular Periods        | Pancreatitis           | Vision Problems         |
| Cancer          | Emphysema            | Irritable Bowel Syndrome | Rashes                 | Vomiting                |
| Chest Pain      | Epilepsy             | Joint/Muscle Pain        | Rheumatic Fever        | Wake to Urinate         |
| Colitis         | Erectile Dysfunction | Kidney Stones            | Rheumatoid Arthritis   | Weight Gain/Loss        |
| Cough           | Fainting             | Lethargy                 | Seizures               |                         |
| Crohn's Disease | Fatigue              | Lumps in the Neck        |                        |                         |
| Constipation    | Fibromyalgia         |                          |                        |                         |

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: \_\_\_\_\_