PsychologicalCare ASSOCIATES
A Division of Child and Family Psychological Services, PLLC

Beth Israel Lahey Health
Beth Israel Deaconess Medical Center

Psychological Care Associates, in partnership with **Beth Israel Lahey Health** provides Behavioral Health Services on-site and in coordination with your doctors. We are a separate practice and must ask you to review and complete these materials in order that you be informed about the care our Behavioral Health Clinicians provide.

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: 781-646-0500 x128. Charges for reproduction of records apply.

Patient Name (**Printed**) _____ Date of Birth ___/___/___

Patient's Signature _____ (Parent/guardian relationship if a dependent) Today's Date ___/___/___

Consent to Evaluation & Treatment:

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. 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 (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

_____ _____/_____/_____

Patient / Guardian *Signature* (Parent/guardian relationship if a dependent) Today's Date

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 (my child's) 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.

E-mail Address	**Name**	**Relationship**
1.		
2.		

_____ _____/_____/_____

Patient Name (**Printed**) Date of Birth

_____ _____/_____/_____

Patient / Guardian *Signature* (Parent/guardian relationship if a dependent) Today's Date

PSYCHOLOGICAL CARE ASSOCIATES @ BETH ISRAEL LAHEY HEALTH

Billing and Payment Policies

Services provided by PCA Behavioral Health Providers are charged separately to your health plan by PCA and are subject to all the provisions of your plan's coverage of Behavioral Health Care, including separate co-payments.

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 $25**, cannot be billed to insurance, and 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 VISA & MasterCard and 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 (781-646-0500 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 781-646-0500 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 781-646-0500 x112. Fees 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 (**Printed**)	Date of Birth / /
Patient / Guardian Signature (Parent/guardian relationship if a dependent)	Today's Date / /

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 (**Printed**) Date of Birth

_____ _____/_____/_____

Patient / Guardian Signature (Parent/guardian relationship if a dependent) Today's Date