

NEW PATIENT INFORMATION

Please fill in the information below as completely as possible. Do not leave any sections blank. If you have questions about this form, please ask your provider for assistance.

Identifying Information:

Patient Name: _____ Today's Date: _____
Gender: _____
Address: _____

Home Phone: _____ Date of Birth: _____
Work Phone: _____ Soc.Sec. #: _____
Responsible Party:(To whom the bills should be addressed?): _____
Relation ship of Responsible Part to patient: _____ Marital Status: _____
Please indicate how you heard about this practice: _____
Name of person filling out this form and relationship to the patient: _____
Emergency Contact: _____

Insurance Information:

Insurance type: _____
ID #: _____ Group #: _____
Name of Subscriber: _____ Gender : _____
Address of Subscriber (if different): _____
Subscriber DOB: _____ Soc. Sec. # of Subscriber: _____
Relationship of Subscriber to patient: _____

Other Information:

Please describe your reasons for seeking treatment, and list the problems which you want help at this time: _____

Please describer any previous or current treatment you have received:

For Office Use Only:

Primary Provider: _____ Fee: _____
Diagnosis _____

Other Information:

Your Name _____

Information Sheet and Consent to Treatment

Welcome to Psychotherapy Associates. We would like to give you a little more information about ourselves, and what to expect during the counseling sessions here. This document contains important information about our professional services and business policies. Please read it carefully and jot down any questions you might have so that we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us.

EMERGENCIES We maintain 24 hour on-call emergency coverage. If you call at a time when there is no one in the office you will have the option of leaving a message for your therapist on voice mail or paging the on call clinician. To reach the on-call clinician in an emergency, call our regular number, press 1, and follow the instructions. If an emergency arises, including suicidal feelings, and you are unable to contact us or feel it is not safe to wait, please call or go to the emergency room of the nearest hospital. These emergency rooms are equipped to handle this kind of problem on a 24 hour basis. Please also leave a message for us so we will be aware of the crisis and can contact you to follow up.

TIME OF APPOINTMENTS Unless we make other arrangements, our appointments are scheduled to last 50 minutes. If an appointment starts late due to our running behind, we will still keep the full 50 minutes. If you arrive late for an appointment, we will have to end the meeting 50 minutes after it was scheduled to begin. The charge to you for these shortened meetings will be for the full amount. You will not be charged for a session if you cannot keep it and let us know at least 24 hours in advance. You will be charged a \$60.00 cancellation fee for any appointments that are cancelled with less than 24 hours notice, or for which you do not show up. This \$60.00 fee is generally not billable to insurance and will need to be paid by you directly. This policy is strictly enforced.

MEDICAL CHECKUP Please get a physical examination from your personal physician as soon as possible. This is important to make sure that none of the problems to be discussed here are the result of physical health difficulties. We work closely with physicians, and we would like to request your permission to contact your doctor. Please indicate if it is all right with you to send periodic updates to your doctor by initialing below:

I do _____ do not _____ give permission to send periodic updates to my physician.

Physician Name: _____

Address: _____

FEES AND PAYMENT A copy of our fee schedule is attached. Payment is expected at the time of each visit. If the sessions are to be billed to insurance, please understand that the payment for these sessions ultimately remains your responsibility. If the insurance company does not pay in full, you agree to be responsible for any unpaid balance. Please be aware that most insurance companies have deductibles, co-payments and limited mental health coverage.

We will do our best to be aware of these payments due from you, and to keep you informed of any changes. However, it is your responsibility to keep track of the number of sessions, dollar amount limits, changes in co-payments, etc. that may be due. Please inform us right away if your insurance coverage changes. If any checks submitted by you are returned for lack of payment by the bank (bounced checks), you will be responsible for reimbursing us for any charges made to us by banks to cover these costs.

In signing this form, you agree that we may bill your insurance company on your behalf, and you agree to ASSIGN PAYMENTS to Psychotherapy Associates of North Reading. This means that you give permission for the insurance payments to be made directly to us. Please be aware that if we are billing insurance, we will need to inform the insurance company of a medical diagnosis. We will be happy to discuss this diagnosis with you, if you request. We may also supply clinical information to the insurance company to the extent that they require this to determine the medical necessity of visits or to pre-approve or pay claims.

CONFIDENTIALITY Privacy is a very important concern for all those who come to this office. It is also complicated because of Federal and State laws and our professional ethics and standards. Because the rules are lengthy and complicated, we have written a Notice of Privacy Policies, which you will find at the end of this packet. We will also require that you sign a consent to these policies before you can be treated here.

In general, the privacy of all communications between a patient and a psychotherapist is protected by law, and we can only release information about our work to others with your written permission. But there are a few exceptions.

In most legal proceedings, you have the right to prevent us from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order our testimony if he/she determines that the issues demand it.

There are some situations in which we are legally obligated to take action to protect you or others from harm, even if we have to reveal some information about a patient's treatment. For example, if we believe that a child, elderly person, or disabled person is being abused, we must file a report with the appropriate state agency.

If we believe that a patient is threatening serious bodily harm to another, we may be required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient. If the patient threatens to harm himself/herself, we may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.

These situations have rarely occurred in our practice. If a similar situation occurs, we will make every effort to fully discuss it with you before taking any action.

We may occasionally find it helpful to consult other professionals about a case. During a consultation, we make every effort to avoid revealing the identity of our patient. The consultant is also legally bound to keep the information confidential. Unless you request otherwise, we will not tell you about these consultations unless we feel that it is important to our work together.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have at our next meeting. We will be happy to discuss these issues with you if you need specific advice, but formal legal advice may be needed because the laws governing confidentiality are quite complex, and we are not attorneys.

SPECIFIC ISSUES RELATED TO THE TREATMENT OF MINOR CHILDREN:

Prior to beginning treatment, it is important for you to understand our approach to child therapy and agree to some rules about your child's confidentiality during the course of his/her treatment.

In the case of divorced and divorcing parents we must have signed consent from both parents in order to treat the minor child. The only exception to this is that if one parent has no legal rights whatsoever to the child and this is almost never the case. If a parent chooses not to involve the other parent in treatment we will decline to see the child without proof of complete loss of legal rights. It is our belief that treatment proceeds best when both parents are involved.

One risk of child therapy involves disagreement among parents and/or disagreement between parents and therapist regarding the best interests of the child. If such disagreements occur, we will strive to listen carefully so that we can understand your perspectives and fully explain our perspective. We can resolve such disagreements or we can agree to disagree, so long as this enables your child's therapeutic progress. Ultimately, you will decide whether therapy will continue. If either parent decides that therapy should end, we will honor that decision, however we ask that you allow us the option of having a few closing sessions to appropriately end the treatment relationship.

Therapy is most effective when a trusting relationship exists between the psychotherapist and the patient. Privacy is especially important in securing and maintaining that trust. One goal of treatment is to promote a stronger and better relationship between children and their parents. However, it is often necessary for children to develop a "zone of privacy" whereby they feel free to discuss personal matters with greater freedom. This is particularly true for adolescents who are naturally developing a greater sense of independence and autonomy. By signing this agreement, you will be waiving your right of access to your child's treatment records. It is our policy to provide you with general information about treatment status. We will raise issues that may impact your child either inside or outside the home. If it is necessary to refer your child to another mental health professional with more specialized skills, we will share that information with you. We will not share with you what your child has disclosed to us without your child's consent. At the end of your child's treatment, we can provide you with a treatment summary that will describe what issues were discussed, what progress was made, and what areas are likely to require intervention in the future.

If your child is an adolescent, it is possible that he/she will reveal sensitive information regarding sexual contact, alcohol and drug use, or other potentially problematic behaviors. Sometimes these behaviors are within the range of normal adolescent experimentation, but at other times they may require parental intervention. We must carefully and directly discuss your feelings and opinions regarding acceptable behavior. If we ever believe that your child is at serious risk of harming him/herself or another, we will inform you.

Although our responsibility to your child may require our involvement in conflicts between the two parents, we need your agreement that our involvement will be strictly limited to that which will benefit your child. This means, among other things, that you will treat anything that is said in session with us as confidential. Neither of you will attempt to gain advantage in any legal proceeding between you and the other parent from our involvement with your children. In particular, we need your agreement that in any such proceedings, neither of you will ask us to write letters to the court on your behalf, or ask us to testify in court, whether in person, or by affidavit. You also agree to instruct your attorneys not to subpoena us or to refer in any court filing to anything we have said or done.

Note that such agreement may not prevent a judge from requiring our testimony, even though we will work to prevent such an event. If we are required to testify, we are ethically bound not to give our opinion about either parent's custody or visitation suitability. If the court appoints a custody evaluator, guardian ad litem, or parenting coordinator, we will provide information as needed (if appropriate releases are signed or a court order is provided), but we will not make any recommendation about the final decision. Furthermore, if we are required to appear as a witness, the party responsible for our participation agrees to reimburse us at our customary rate of \$200.00 per hour for time spent traveling, preparing reports, testifying, being in attendance, and any other court-related costs.

I have read and discussed the above agreement with my therapist. I understand and agree to all of the points discussed above. If at any point I have questions or problems regarding my treatment here I understand that Psychotherapy Associates has a grievance procedure. This is to first try to resolve any difficulties with your therapist. If this does not prove satisfactory, the next step is to contact either of the two Co-Directors: Donna Whipple or Richard Kaufman.

Client

Date

Therapist

Date