Psychotherapy Associates of North Reading and Amesbury
5 Market Square, Suite 102, Amesbury, MA 01913
Phone: 978-664-2566, Fax: 978-664-8023

Revised 6/2023

Client Name: _____

Parent or guardian:_____

Address: _____

_____

Home Phone: _____ OK to call ? ____ DOB:_____

Work Phone: _____ OK to call? ____ Soc.Se. #_____

Email:_____

Referred by: _____

Insurance: _____ Card #: _____

Insurance Phone #:_____

Subscriber: _____ Subscriber DOB: _____

Previous and/or current treatment: _____

Medications: _____

Emergency Name_____

Emergency Number_____

Welcome to Psychotherapy Associates. We would like to give you a little more information about our telehealth practice, 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 for existing clients only. 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 or call 911. These emergency resources 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 The length of your appointment will depend on the clinical need but are generally either 45 or 57 minute sessions. If you arrive late for an appointment, we will have to end the meeting at the time it was scheduled to end. 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 $80.00 cancellation fee for any appointments that are cancelled with less than 24 hours notice, or for which you do not show up. This $80.00 fee is 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: _____
Phone: _____

FEES AND PAYMENT A copy of our fee schedule is attached. Payment is expected at the time of each visit. We are fully remote so we require that you keep a valid credit card on file so charges can be made as they accrue. 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, for any reason, you agree to be responsible for any unpaid balance. It is your responsibility to make sure that your insurance covers telehealth visits. 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 also be aware that if you are seeing another mental health provider, both services may not be covered. Please let us know if this is the case. If you have seen another mental health provider within the past year please let us know this as it may affect how many sessions are authorized. 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 & Amesbury. This means that you give permission for the insurance payments to be 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 are seen in our practice. It is also complicated because of Federal and State laws and our professional ethics and Policies, which you will find at the end of this packet. We will also require that you sign consent to these policies before you can be treated here.

In general, the privacy of all communications between a patient and 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 our 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 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 ISSURES 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 interest 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. You must understand that we are not qualified or allowed to give opinions about visitation and custody. This is the specialty of Parent Coordinators and GALs. Please do not ask us for opinions on these matters and if you perceive that we are giving you opinions on these matters it is likely a misunderstanding that you should seek to clarify with us. Please do not ask us to write letters to the court on your behalf. Again, this is not the work of a psychotherapist. We treat behavioral health issues; we are not trained custody evaluators.

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.
It is our policy to provide you with general information about treatment status. We would like a frank discussion with the parents and child about what would be shared with parents in advance of the treatment and consistent with reporting laws. 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.

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 parent 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. In cases of impending divorce or actual divorce, children have independent privilege under the law. This means that we cannot talk to parent's attorneys, GAL's or release records even to parents without a formal waiver of the privilege by a judge.

Note that such agreement between us 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 $300.00 per hour for time spent traveling, preparing reports, testifying, being in attendance, and any other court-related costs.

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.

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.

IMPORTANT INFORMATION FOR COUPLES OR FAMILY THEREAPY

In cases of couples or family therapy, there are particular things you need to understand in advance of therapy. When a couple is seen, one person is identified as the primary client. It is their insurance that is billed and their diagnosis that is used to bill insurance. We will assess with you which of the couple or family member is most appropriate to be the identified client. What this means though is that other people attending the session that are not the primary client are not considered to be a client. Our responsibility is to the client and their interests are primary. Again, to be clear, there is a primary client and one or more collaterals. A collateral is usually a spouse, family member, or friend, who participates in therapy to assist the identified client. The role of a collateral will vary greatly. For example, a collateral might attend only one session, either alone or with the client, to provide information to the therapist and never attend another therapy session. In another case a collateral might attend all of the client's therapy sessions and his/her relationship with the client may be a focus of the treatment. There are some risks and benefits to being a collateral. Psychotherapy often engenders intense emotional experiences, and your participation may engender strong anxiety or emotional distress. It may also expose or create tension in your relationship with the patient. While your participation can result in a better understanding of the client or an improved relationship, or may even help in your own growth and development, there is no guarantee that this will be the case. Psychotherapy is a positive experience for many, but it is not helpful for all people. With regard to medical records, no record or chart will be maintained on a collateral. Notes about a collateral are entered into the client's chart. The client has the right to access the chart and the material contained therein. It is sometimes possible to maintain the privacy of our communications with collaterals. If that is your wish, we should discuss it before any information is communicated. The collateral has no right to access the chart without written consent of the identified client. The collateral will not carry a diagnosis, and there is no

individualized treatment plan for them. Collaterals are not responsible for paying any fees for our services unless you are financially responsible for the client. Collateral are expected to maintain the confidentiality of the client.

Do collaterals ever become a formal client? Collaterals may discuss their own problems in therapy, especially problems that interact with issues of the identified client. The therapist may recommend formal therapy for a collateral. This may happen if it becomes evident that the collateral is in need of their own mental health services. In this case the collateral would need to have their own clinician, diagnosis and chart record. More often than not the clinician will refer you to another therapist to avoid a dual role. One exception to this is when a family therapy approach can effectively and ethically used to treat all members of the family or each of the couple.

The primary client is not required to sign a release of information authorization to the collateral when the collateral participates in therapy. The presence of the collateral with the consent of the client is adequate; however, it is our practice to require such an authorization. This provides some assurance that full consent has been given to the clinician for the client's confidential information to be discussed with the collateral in therapy. The authorization form is also helpful when the clinician calls or receives a call from a collateral for one reason or another. In most instances the clinician cannot take a call from a collateral without a release authorization form signed.

When parents are collaterals: In treatment involving children and their parents, access to information is an important and sometimes contentious topic. Particularly for older children, trust and privacy are crucial to treatment success. But, parents also need to know certain information about the treatment. For this reason we will discuss and agree about what information will be shared and what will remain private at the outset of treatment and review it as needed. If you are participating in therapy with your child we may give you parenting advice but you are still the collateral, not the client.

ELECTRONIC COMMUNICAITONS POLICY

Speak with your therapist about whether they use email or texting for routine administrative communication. We use email or text messaging only with mutual agreement of the client and the therapist and only for administrative purposes such as scheduling or rescheduling appointments. Please do not text or email us about clinical matters because it is not a secure form of communication. Telephone, videoconferencing or face to face is the most secure mode of clinical communication. Also, we do not communicate with any of our clients through social media platforms like Twitter or Facebook. If we discover that we have accidentally established a relationship with a client we will cancel it. This is because these types of casual social contact can create significant security risks to you. Our therapists participate in various social networks but not in their professional capacity. If you have an online presence, there is a possibility that you may encounter them by accident. Please let us know in person if this happens as it needs to be discussed as it has a high potential to compromise the professional relationship. Please do not try to contact us this way. We will not respond and will terminate any online contact no matter how accidental. We have a professional website that you are free to access. We use it for professional reasons to provide information to others about our practice.

We recognize that this is a lot of information to take in. Please make sure you read it carefully and bring up any concerns before you sign it. If you refer to reschedule the session in order to review this paperwork more fully please feel free to do so. Please keep a copy for your own records, though we will also maintain one should you need it. Feel free to ask us at any time to provide you with this information again. It is available on our website.
Please let us know ASAP if you have a change of address or phone number. We do not want to send bills to an old address or leave voicemails about appointment changes or cancellations on old phone numbers as that can compromise your privacy.

I have read and discussed the above agreement with my therapist. I understand and agree to all of the points discussed above. I have received and understand the Notice of Privacy Policies. 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. Please remember that the best way to assure quality and ethical treatment is to keep direct and open communication with your therapist. By signing below you indicate that you have read and understand this document.

ISSUES SPECIFIC TO TELEHEALTH

Benefits and Risks of Telepsychology
Telepsychology refers to providing psychotherapy services remotely using telecommunications technologies, such as phone or video conferencing. One of the benefits of telepsychology is that the client and clinician can engage in services without being in the same physical location. Telepsychology, however, requires technical competence on both our parts to be helpful. Although there are benefits of telepsychology, there are some differences between in-person psychotherapy and telepsychology, as well as some risks. For example:

- Risks to confidentiality. Because telepsychology sessions take place outside of the therapist's private office, there is potential for other people to overhear sessions if you are not in a private place during the session. On my end I will take reasonable steps to ensure your privacy. But it is important for you to make sure you find a private place for our session where you will not be interrupted. It is also important for you to protect the privacy of our session on your cell phone or other device. You should participate in therapy only while in a room or area where other people are not present and cannot overhear the conversation.
- Issues related to technology. There are many ways that technology issues might impact telepsychology. For example, technology may stop working during a session, other people might be able to get access to our private conversation, or stored data could be accessed by unauthorized people or companies.
- Crisis management and intervention. Usually, I will not engage in telepsychology with clients who are currently in a crisis situation requiring high levels of support and intervention. Before engaging in telepsychology, we will develop an emergency response plan to address potential crisis situations that may arise during the course of our telepsychology work.

- Efficacy. Most research shows that telepsychology is about as effective as in-person psychotherapy. However, some therapists believe that something is lost by not being in the same room. For example, there is debate about a therapist's ability to fully understand non-verbal information when working remotely. Increasingly, however, studies are showing that telehealth is as effective as in person and often the client appreciates not having to travel to the session.
- Miscommunication. With non face to face interactions occur there is a higher risk of miscommunication or misunderstanding. I ask that if you feel that this might have happened you will make sure to bring this up to me. For example, if we are communicating by text or email there can be typos or autocorrects that are not what was meant. If you think this has happened please bring it up.

Electronic Communications

I use a platform called Doxy.me. It is HIPPA compliant. At our scheduled time, I will send an email invitation to you, that will look something like this**:** https://doxy.me/ and after you click the link provided, you will be directed to my virtual waiting room and I will be notified that you are there. To meet with me on Doxy.me you will need to use Chrome, Firefox, or Safari browsers and a web-camera and microphone on your phone or computer. If there is a technological failure and we are unable to resume the connection, you will only be charged the prorated amount of actual session time. I may also use a HIPAA compliant version of Zoom. We may also use the phone for sessions when appropriate.

Fees

The same fee rates will apply for telepsychology as apply for in-person psychotherapy. However, insurance or other managed care providers may not cover sessions that are conducted via telecommunication. If your insurance, HMO, third-party payor, or other managed care provider does not cover electronic or phone psychotherapy sessions, you will be solely responsible for the entire fee of the session. Please contact your insurance company prior to our engaging in telepsychology sessions in order to determine whether these sessions will be covered. As stated above, we require a credit card on file with fees to be charged as they accrue.

Records

The telepsychology sessions shall not be recorded in any way unless agreed to in writing by mutual consent. I will maintain a record of our session in the same way I maintain records of in-person sessions in accordance with my policies.

SIGNATURE OF CONSENT TO ALL OF THE POLICIES ABOVE:

_____ _____

Client Date

_____ _____

Therapist Date

PERMISSION TO CHARGE CREDIT/DEBIT CARD:

Psychotherapy Associates of North Reading and Amesbury
Credit Card Authorization Form

Name: _____

Patient Name, if different: _____

I hereby authorize Psychotherapy Associates of North Reading and Amesbury to charge my credit card in the amount of my balance, whenever I have a balance due for my services at Psychotherapy Associates.

Please initial on the line below, fill in your credit card information, sign and date this form.

Thanks very much,

Rick Kaufman

_____ Please charge my credit card in the amount of my invoice whenever I have a balance due.

My credit card number is: _____

The expiration date is: _____

The 3 digit Security Code from the back of the card is: _____

_____ _____
Signed Date

Psychotherapy Associates of North Reading and Amesbury
5 Market Square, Suite 102
Phone: 978-664-2566, Fax: 978-664-8023
www.panr.net

NOTICE OF PRIVACY POLICIES TO PROTECT THE PRIVACY OF YOUR HEALTH INFORMATION

REVISED 6/15/2023

This notice describes how psychological and medical information about you may be used and disclosed and how you can get access to this Information.

Please Read it Carefully

1. Uses and Disclosures for Treatment, Payment and Health Care Operations

I may *use* or *disclose* your *protected health information* (PHI), for *treatment*, *payment*, *and health care operations* purposes with you *consent*. To help clarify these, here are some definitions:

- "PHI" refers to information in your chart that could identify you.
- "*Treatment, Payment and Health Care Operations*"

  Treatment is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your PCP or another therapist.

  Payment is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for you health care or to determine eligibility or coverage.

  Health Care Operations are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters, such as audits and administrative services, and case management and case coordination.

  Use applies to activities within my practice, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.

  Disclosure applies to activities outside of my practice, such as releasing, transferring, or providing access to information about you to other parties.

2. Uses and Disclosures Requiring Authorization

- I may use or disclose PHI for purposes outside of treatment, payment and health care operations when your appropriate authorization is obtained. An "*authorization*" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization from you before releasing your psychotherapy notes. "*Psychotherapy notes*" are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your chart. These notes are given a greater degree of protection than PHI. It is PANR's policy not to keep separate psychotherapy notes. All documentation we keep is a part of your clinical chart.
- I will also obtain an authorization from you before using or disclosing PHI in a way that has not been described I this notice.
- I will not use your PHI for marketing or sales purposes under any conditions.

3. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse**: If I, in my professional capacity, have reasonable cause to believe that a minor child is suffering physical or emotional injury resulting from abuse inflicted upon him or her which causes harm or substantial risk or harm to the child's health or welfare(including sexual abuse), or from neglect, including malnutrition, I must immediately report such a condition to the Massachusetts Department of Children and Families.
- **Adult and Domestic Abuse:** If I have reasonable cause to believe that an elderly person (age 60 or order) is suffering or has died as a result of abuse, I must immediately make a report to the Massachusetts Department of Elder Affairs.
- **Health Oversight:** The Board of Registration that applies to my particular license to practice has the power, when necessary, to subpoena relevant records should I be the focus of an inquiry.
- **Judicial or Administrative proceedings:** If you are involved in a court proceeding an a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law and I will not release information without written authorization from you or your legally-appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the court evaluation is court ordered. You will be informed in this case.
- **Serious Threat to Health or Safety:** If you communicate to me an explicit threat to kill or inflict serious bodily injury upon an identified person and you have the apparent intent and ability to carry out he threat, I must take reasonable precautions. Reasonable precautions ma include warning the potential victim, notifying law enforcement, or arranging for your hospitalization. I must also do so if I know you to have aa history of physical violence and I believe there is a clear and present danger that you will attempt

to kill or inflict bodily injury upon an identified person. Furthermore, if you present a clear and present danger to yourself and refuse to accept further appropriate treatment and I have a reasonable basis to believe that you can be committed to a hospital, I must seek said commitment and may contact members of your or other individuals if it would assist in protecting you.

- **Workers Compensation:** If you file a worker's compensation claim, your records relevant to that claim will not be confidential to entities such as your employer, the insurer and the Division or Worker's Compensation.
  When the use and disclosure without your consent or authorization is allowed under sections of Section 164.512 of the Privacy Rule and the state's confidentiality law, this includes certain narrowly defined disclosures to law enforcement agencies, to a health oversight agency (such as HHS or a state department of health), to a coroner or medical examiner, for public health purposes relating to disease for FDA-regulated products, or for specialized government functions such as fitness for military duties, eligibility for VA benefits, and national security and intelligence.

4. Patient's Rights and Mental Health Clinician's Duties

Patient's Rights:

- **Right to Request Restrictions**: You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.
- **Right to Receive Confidential Communications by Alternative Means and Alternative Locations**: You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (for example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address).
- **Right to Inspect and Copy**: You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases, you may have the decision reviewed. On your request, I will discuss with you the details of the amendment process.
- **Right to Amend**: You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.
- **Right to an Accounting**: You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, I will discuss with you the details of the accounting process.
- **Right to a Paper Copy**: You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.
- **Right to Restrict Disclosures When You Have Paid for Your Care Out-of-Pocket**: You have the right to restrict certain disclosures of PHI to a health plan when you pay out-of-pocket or in full for my services.

- **Right to Be Notified if Thee is a Breach of Your Unsecured PHI**: You have a right to be notified if (a) there is a breach (a use or disclosure of your PHI in violation of the HIPAA Privacy Rule) involving your PHI; (b) that PHI has not been encrypted to government standards; and (c) my risk assessment fails to determine that there is a low probability that your PHI has been compromised.

Mental Health Clinician's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in the notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect. If I revise my policies and procedures, I will notify current clients and post the new policies in the waiting area.

5. Complaints

If you are concerned that I have violated our privacy rights, or you disagree with a decision I made about access to your records, you may contact our Privacy Officer: Dr. Donna Whipple at this office x223. If you are a client of Dr. Whipple you may contact Richard Kaufman LICSW at this office x211. You may also send a written complaint to the Secretary of the U.S Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

6. Effective Date and Changes to Privacy Policy

This notice will go into effect June 15th, 2023. I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will notify current clients of changes in person or by mail and closed client cases can, if interested, call and ask if our policies have changed and obtain a copy by mail or view one on our website.

Psychotherapy Associates of North Reading and Amesbury
5 Market Square, Suite 102
Phone: 978-664-2566, Fax 978-664-8023

www.panr.net

CONSENT TO USE AND DISCLOSE YOUR HEALTH INFORMATION SIGNATURE PAGE

This form is an agreement between you_____ and Psychotherapy Associates of North Reading and Amesbury. When we use the word "you" below it will mean your child, relative, or other person if you have written his name here.

When we examine, diagnose, treat, or refer you we will collecting what the law calls Protected Health Information (PHI) about you. We need to use this information here to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others who provide treatment to your or need it to arrange payment for your treatment or for other business or government functions.

By signing this form you are agreeing tat you have read and understand our Notice of Privacy Policies and you are agreeing to let us use your information here and send it to others in accordance with our written policies. Please make sure you have read and understand our Privacy Policies above before signing this Consent form.

If you do not sign this consent form agreeing to what is in our Notice of Privacy Policies, we cannot treat you.

In the future we may change how we use and share your information and so may change our Notice of Privacy Policies. If we do change it, you can get a copy from our website: www.panr.net, or by calling us at 978-664-2566 x223, or from our privacy officer, Dr. Donna Whipple.

If you are concerned about some of your information, you have the right to ask us not to use or share some of your information for treatment, payment or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations. However, if we do agree, we promise to comply with your wish.

After you have signed this consent, you have the right to revoke it (by writing a letter telling us you no longer consent) and we will comply with your wishes about using or sharing your information from that time on but we may already have used or shared some of your information and cannot change that.

Signature of client or personal representative	Printed name of client or personal representative
Date of Signature	Date NPP received by client or representative

FOR MASS HEALTH CLIENTS ONLY
PSYCHOTHERAPY ASSOCIATES OF NORTH READING and AMESBURY

5 Market Square
Amesbury, MA 01913

Telephone: (978) 664-2566
Fax: (978) 664-8023

Donna Whipple PsyD, Licensed Psychologist

Richard Kaufman, MSW, LICSW

Orientation to Treatment Information
Addendum for Clients with Mass Health Products

I have received the following information forms:

_____ After Hours Instruction (on general consent to treatment form)

_____How to file a Complaint (attached)

_____Privacy Notice (attached to consent to treatment form)

_____Rights (attached, please sign)

_____Other_____

_____
Member/Guardian Signature

_____
Date

MBHP How to File A Complaint
About Your Healthcare

The Massachusetts Behavioral Health Partnership (the Partnership) wants you to Receive the best mental health and substance abuse services possible. We are under Contract with the Massachusetts Division of Medical Assistance to manage these Services for many people who have MassHealth (Medicaid) insurance.

We know that sometimes problems happen. You have a right to complain if you are not happy with the service you or a family member received from a provider. Perhaps you were not treated with respect, or you had to wait too long to get an appointment.

If this happens, you have the right to make a formal complaint. Just follow these steps:

1. First, tell your provider about your concerns.
2. If you do not like the provider's response, you can call the Partnership at 800.495.0086. There will be no action against you for making a complaint.
3. If you cannot resolve your complaint the same day, the Partnership may ask you to put your complaint in writing. We can help you do this. You can also call the Partnership about a family member or a friend. If he or she is an adult, we will need to ask for their approval for you to share information with us.
4. Once we have the information we need, the Partnership's Quality Coordinator will review your complaint. During this review, the Partnership might contact providers involved in your complaint.
5. You will receive a letter about your complaint within 15 days.

Contact information

- You can *call* the Partnership at 1-800-495-0086 to file a complaint.
- You can *write* us at:

  Massachusetts Behavioral Health Partnership
  286 Congress Street, Seventh Floor
  Boston, MA 02110

For help with any problem connected with a behavioral health service, please call the Partnership clinicians. They can be reached at 1-800-495-0086.

MBHP-RECOMMENDED MEDICAL RECORD FORM
Psychotherapy Associates of North Reading and Amesbury

5 Market Square, Suite 102 **Telephone: (978) 664-2566**
Amesbury, MA 01913 **Fax: (978) 664-8023**
Donna Whipple, PsyD, Licensed Psychologist

Richard Kaufman, MSW, LICSW

Notice of Member Rights
(Taken from DMH regulations 104 CMR28.00

1. You have the right to be free from discrimination on the basis of race, creed, religion, sex, sexual orientation, age or physical or mental disability.
2. You have the right to religious freedom and practice.
3. You have the right to have reasonable access to a telephone to make and receive confidential calls.
4. You have the right to be represented by an attorney or advocate of your own choice.
5. You have the right to be protected from commercial exploitation.
6. You have the right to a humane and psychological and physical environment.
7. You have the right to receive and inspect a copy of your record.
8. You have the right to confidentiality of your case record.
9. You have the right to participate in your own treatment planning and to give informed and consent to recommended therapy, including medication.
10. You have the right to be free from mistreatment.
11. You have the right to send and receive mail and to be provided with reasonable amounts of writing material and postage.
12. You have the right to visit and be visited by others.
13. You have the right to be free from unreasonable searches.
14. You have the right to acquire, retain, and dispose of your own possessions.
15. You have the right to file complaints.
16. You have the right to vote.

If you believe that your rights or the rights of another patient have been violated, you should notify a staff member or the director of the program should be contacted to file a complaint.

I have read and understand the Notice of Patients' Rights agreement listed above.

_____ _____
Member/Parent/Guardian **Date**