Psychological Associates
92 High Street DH7
Medford, Massachusetts
781-393-8889

PATIENT INFORMATION

Patient Name: _____ D.O.B. _____

Address: _____ City _____ State: _____

Zip Code _____ Social Security Number_____

Sex: M ☐ F ☐ Marital Status: S ☐ M ☐ W ☐ D ☐

If under 18, Parent/Guardian name: _____

Home Phone: _____ Work Phone_____ Cell Phone _____

Occupation: _____ Employer: _____

Family members: Name	Relationship	D.O.B.
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medications: _____

Emergency Contact: _____ Relationship: _____

Phone _____

Primary Care Physician: _____Telephone: _____

Referred by: _____ Relationship: _____

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FINANCIAL AGREEMENT

Patient Name: _____Date: _____
Insurance Carrier: _____Telephone:_____
Subscriber:_____ Subscriber Birthdate_____
Employer:_____Policy #_____Group#:_____
Authorization# _____ Number of Sessions: _____
Mail Claims To: _____
_____
Telephone # of insurance company _____

Does your insurance company require you to pay a "deductible"? _____
If so, how much is the deductible payment? _____
Do you have a secondary insurance carrier? _____
Do you know whether your mental health coverage is provided (or "carved out" to) be another insurance carrier? _____

Fees Schedule:

Initial Evaluation	$ _____
Individual Therapy (20-30 min.)	$ _____
Individual Therapy (45-50 min.)	$ _____
Couple/Family Therapy	$ _____
Group Therapy	$ _____
Psychological Testing	$ _____

Payment Policy:

Out-of-pocket payments and copayments are due at the time of service unless there is a special arrangement defined ahead of time.

Insurance payments are accepted per contracted fee schedule. Patients are responsible for co-payments and deductibles established by the insurer.

Medical Release and Assignment of Benefits:

I authorize the release of any medical or other information necessary to process insurance claims for services rendered to me, or my dependents by_____.
(Name of clinician)

I also authorize payment of medical benefits to _____ for psychotherapeutic services

Signature _____ Date: _____
(Guardian if patient is under 18)

It is my (patient/parent or guardian) responsibility to know my insurance benefits. Therefore, I am responsible for any non-covered services rendered to my dependent or me. I agree to pay any co-payments, deductibles as established by my insurer.

Signature _____ Date: _____
(Guardian if patient is under 18)

Cancellation Policy

I understand that I am personally responsible for the fee for any appointment canceled with less than 48 hours, or two business days notice. This fee is my personal responsibility and can not be billed to my insurance company.

Signature _____ Date: _____
(Guardian if patient is under 18)

Authorization to Release Confidential Information

I authorize Psychological Associates to disclose and make available information regarding my mental health status to my insurance company in written form or verbally for the purposes of reimbursement. I understand that this information may include, but is not limited to the following categories: clinical diagnosis; details of psychosocial history and description of my present functioning; dates of service, treatment plans and goals.

I recognize that Psychological Associates cannot guarantee the confidentiality of my records when they are released to third party payers. I understand that this data may remain in a data bank which could be called upon at some future time when I apply for another health insurance policy, life insurance policy, or disability insurance policy.

_____ _____
Signature of person/guardian releasing information Date

Member:_____
Name:_____ Date of Birth:_____
Insurance:_____

Behavioral Health Provider **Primary Care Provider**
Name:_____
Address:_____
_____
_____
_____
Phone:_____
Phone:_____Fax:_____

I, (print member name and address)

_____
_____

give permission to_____and_____
(Behavioral Health Provider) *(Primary Care Provider)*
to exchange the following information for the purpose of coordinating my treatment, care and follow up:

( ) Information limited to my diagnosis, treatment plan, medications, expected duration of treatment and medical alerts directly related to my safety and well-being including such information related to treatment for alcohol or drug abuse, an mental health issues; OR

( ) Other information (please specify)_____

Such permission for the exchange of information does not include results of any blood tests to the human immunodeficiency virus (HIV).

I may cancel this one consent at any time except t the extent that information has already been exchanged in reliance on this authorization. If not canceled, this consent will expire one year from the last day of mental health, alcohol or drug abuse treatment. I understand that records regarding alcohol and drug treatment may be protected under Federal Regulation 42 CFR, Part 2, Confidentiality of Alcohol and Drug Abuse Treatment Patient Records and I hereby authorize the release of such records if I have so indicated above. I understand that I do not have to sign this form to receive benefits under the conditions of the health plan to which I belong. I understand that in an emergency situation my providers may exchange information about me to the extent allowed by law.

Signature of member, legal representative, or guardian:_____
Date:_____

I do not authorize my providers to exchange information as described above. I understand that my decision to refuse authorization could have adverse impact on my care. I understand that in an emergency situation my providers may exchange information about me to the extent allowed by law.

Signature of member, legal representative, or guardian:_____
Date:_____

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CONFIDENTIALITY POLICY

Patient/Clinician

Confidence in patient/clinician confidentiality is one of the major factors of successful psychotherapy. Both verbal communication and written records are confidential and are protected by law. Written patient release for information is usually required for the transfer of records. However, there are some exceptions where information may be shared without a patient release. We feel that it is important that you are informed of these exceptions:

1. **ABUSE:** Abusive treatment and/or neglect to a child, elderly, or a disabled person is reported to the proper agency.
2. **HARM:** Threat of serious bodily harm to oneself or others is reported. Provider may seek the client's hospitalization, and notification to any or all of the following my be warranted:
    - The potential victim
    - Family members
    - Police
3. **LEGAL/COURTS:** In some legal proceedings, upon a court order, testimony and/or records may be rendered.
4. **SELF DEFENSE:** If legal actions are brought against clinician by the patient and/or family, information may be disclosed if necessary and relevant to the case.
5. **CHILDREN:** General feedback on the treatment progress is reported to the parents/guardians of children under 18.
6. **PEER CONSULTATION:** Occasionally, peer consultation is needed for the success of treatment. In these cases, no names will be disclosed in order to protect confidentiality.
7. **INSURANCE:** Disclosing information to a third-party payer and/or MCO for the purposes of administering benefits and managing care.
8. **PAYMENTS:** Information (name/address/dx/$) may be disclosed to a billing or collection service for the purpose of collecting the payments owed for services rendered.

PATIENT SIGNATURE: _____

PATIENT NAME: _____

DATE: _____

PATIENT STRESS QUESTIONNAIRE

Name:_____

Date: _____ Birth date:_____

Over the **last two weeks**, how often have you been bothered by any of the following problems? *Please circle your answer and check the boxes that apply to you*	Not at all	Several Days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down depressed, or hopeless	0	1	2	3
5. ☐ Trouble falling or staying asleep, or ☐ Sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. ☐ Poor appetite, or ☐ Overeating	0	1	2	3
6. Feeling bad about yourself or that you are a failure , or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. ☐ Moving or speaking so slowly that other People could have noticed, or ☐ The opposite – being so fidgety or restless that you've been moving around a lot more than usual	0	1	2	3
9. ☐ Thoughts that you would be better off dead, or ☐ Hurting yourself in some way	0	1	2	3
ADD COLUMNS				
TOTAL (Add columns)				

1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
ADD COLUMNS				
TOTAL (Add columns)				

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that,

in the **past month** you:

1. Have had nightmares about it or thought about it when you did not want to?	No	Yes
2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?	No	Yes
3. Were constantly on guard, watchful, or easily startled?	No	Yes
4. Felt numb or detached from others, activities or your surroundings?	No	Yes

Please circle your answer	Never	Monthly or less	2-4 times a month	2-3 times a week	4+ times per week
How often do you have one drink containing alcohol?	0	1	2	3	4
How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3-4	5-6	7-9	10 or more
How often do you have four or more on one occasion?	0	1	2	3	4

How often during the last year have you…	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
…found that you were not able to stop drinking once you had started?	0	1	2	3	4
…failed to do what was normally expected from you because of drinking?	0	1	2	3	4
…needed a first drink in the morning to get yourself going after a heavy drinking session?	0	1	2	3	4
…had a feeling of guilt or remorse after drinking?	0	1	2	3	4
…been unable to remember what happened the night before because you had been drinking?	0	1	2	3	4

	No	Yes, not in the last year	Yes, during the last year
Have you or someone else been injured as a result of your drinking?	0	2	3
Has a relative, friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	0	2	3
			Total