SOUTHCOAST
COUNSELING ASSOCIATES

Southcoast Counseling Associates
52 Brigham St, Suite 5,
New Bedford, MA 02740

Date _____/_____/_____

PLEASE PROVIDE THE FOLLOWING INFORMATION:

Client Name: _____ SSN: _____

Address: _____
STREET APT. # CITY/TOWN STATE

Phone (Home): _____ Phone (Cell): _____

Email Address: _____

Employed: ☐ Y ☐ N Phone (Work): _____ Date Of Birth: ____/____/_____ Age:_____

Sex: ☐ M ☐ F Marital Status: ☐Single ☐ Married ☐Separated ☐Divorced ☐Widowed

Emergency Contact: _____ _____
NAME (RELATIONSHIP) PHONE NUMBER

Is Your Visit Work Related? ☐Y ☐N Accident Related? ☐Y ☐N

Primary Care Physician: _____ _____
NAME ADDRESS PHONE NUMBER

Referral Source: _____ _____
NAME ADDRESS PHONE NUMBER

Health Insurance: _____

Member #: _____ Group #: _____
(IF APPLICABLE)

Subscriber: _____ Date Of Birth: ____/____/_____
NAME

Subscriber Address: _____
STREET APT. # CITY/STATE ZIP

Subscriber Phone: _____ Subscriber Employer: _____

(PLEASE COMPLETE INFORMATION BELOW ***ONLY*** IF YOU HAVE ADDITIONAL INSURANCE)

Other Health Insurance? ☐Y ☐N If so, Insurance Name: _____

Member # (for second insurance): _____

Subscriber: _____ Subscriber Date of Birth: ____/____/_____

Subscriber Address: _____

FOR OFFICE USE ONLY.

- INITIAL AUTHORIZATION #: _____
- DATES: ____/____/____ THROUGH: ____/____/____
- SESSIONS AUTHORIZED: _____ OR $$$ _____
- CO-PAY: _____ DEUCTIBLE: _____

90791: (date) ____/____/____
DX(s) (____/____) _____
DX(s) (____/____) _____
DX(s) (____/____) _____
Next Scheduled Session ☐90834 or ☐90847 (date) ____/____/____ (time) _____

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OFFICE POLICIES AND CONSENT TO TREATMENT

OFFICE POLICIES

We are committed to providing you with quality care. The following office policies are for your information. Should you have any questions or concerns regarding these policies, please speak with your therapist as soon as possible.

Insurance: If certain insurance carriers or HMO's insure you , this office can bill the insurance carrier directly to the extent of your policy's coverage for psychotherapy sessions. Co-payments and deductibles are the client's responsibility to pay directly at the time of service. Services provided beyond the limits of annual coverage are to be paid directly by the client. Unless otherwise arranged, clients covered by all other insures must pay for services_ privately and obtain reimbursement directly from the insurance company.

Fee schedule: Payments are due at the time of appointment unless otherwise agreed upon. The following schedule lists the standard fees most commonly requested services;

Diagnostic Evaluation	**(45-50 minutes)**	**$200.00**
Family / Couple Psychotherapy	**(45-50 minutes**	**$145.00**
Individual Psychotherapy	**(45-50 minutes)**	**$125.00**
Group Therapy	**(45-50 minutes)**	**$75.00**

Cancellations and Missed Appointments: If you are unable to keep a scheduled appointment, ***24 hour notice is required for cancellation***. Failure to attend a scheduled appointment will result in being charged the full fee unless prohibited by federal regulations. This is not billable to your insurance company, and is payable at your next appointment. Please consult with your therapist regarding his or her particular cancellation and missed appointment policy.

Emergency Coverage: Our practice is covered live, twenty-four hours per day, accessible through our main phone number, 508-993-8332. If you identify your call as an emergency, the secretary or answering service will contact your therapist, and your therapist will call you back promptly. If for some reason you are not able to call us, you should go to the nearest emergency room or crisis center.

Contact with Primary Care Provider: By signing below I give my therapist permission to communicate with my primary care physician _____ and/or treating psychiatrist/nurse practitioner _____ regarding my treatment to assure continuity of care, if necessary.

_____ is an independent clinician and will be providing treatment to you or your family members in that capacity. Southcoast Counseling Associates is an association of independent practitioners for the sole purpose of cost sharing expenses. Your therapist may have you sign a separate document for this purpose.

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CONSENT TO TREATMENT

I have read all of the information on this sheet and have completed the answers on the other side. I am also aware that my rights as patient are posted in the waiting area for my review. I have been offered a copy of Southcoast Counseling Associates Notice of Privacy Practices and understand that I may discuss any questions about this notice with my therapist.

I certify that this information is true and correct to the best of my knowledge. I will notify you of any changes in my health insurance status or any information requested. Payment is required within 30 days from the date of bill. I acknowledge that I have received a copy of the Notice of Privacy Practices and Business Policies.

If you have any concerns, complaints or questions about your treatment you are encouraged to share them with your therapist.

By signing this document, I acknowledge that I have read the above Agreement of Understanding and give Informed Consent to treatment services as well as agree to the policies set forth in the Agreement. I hereby give permission to initiate and conduct treatment for myself and/or family member(s).

_____ _____

Client Signature (if minor Parent, or Legal Guardian) Date

_____ _____

Client Signature (if minor Parent, or Legal Guardian) Date

_____ _____

Client Signature (if minor Parent, or Legal Guardian) Date

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RELEVANT MEDICAL INFORMATION

Today's Date: _____

Name: _____ DOB: _____

Address: _____ City/State/Zip: _____

Home Phone #: _____ Cell Phone #: _____

Primary Care Physician: _____ Phone #: _____

Please list the date of your last physical exam: _____

Please check an that apply:

- ☐ Anemia
- ☐ Blackouts
- ☐ Bleeding
- ☐ Bone Disease
- ☐ Breast Problems
- ☐ Cancer
- ☐ Delirium Tremens (DTs)
- ☐ Diabetes
- ☐ Dizziness/Fainting
- ☐ Genitalia Problems
- ☐ Headaches
- ☐ Hearing Problems
- ☐ Heart Disease / Circulatory Disorder
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Memory Problems
- ☐ Menstruation Problems
- ☐ Numbness/Tingling
- ☐ Previous Pregnancies
- ☐ Seizure Disorders
- ☐ Stomach or Intestinal Disorder
- ☐ Tuberculosis
- ☐ Venereal Disease (Herpes, Gonorrhea, etc.)
- ☐ Visual Problems
- ☐ Walking Problems or Poor Balance
- ☐ Are you or could you be pregnant now?

Please list any allergies (food, medication, other) that you have: _____

_____

_____

Please list any operations that you have had: _____

_____

_____

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Please list any/all medication(s) that you are currently taking: _____

_____

_____

****

FOR OFFICE USE ONLY

Medication Changes: _____

_____

_____

Date: _____

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COORDINATION OF CARE COMMUNICATION FORM

Date: _____ MD Name: _____

Patient: _____ MD Address: _____

_____

Date of Birth: _____/_____/_____ Phone: _____

This information is provided to facilitate coordination of treatment/continuity of care.

I saw this patient on: _____

DSM IV Diagnosis: _____

The recommended treatment is: _____

_____

Please call me if you need to discuss this case further or if you require further information.

_____ _____ _____

Signature Name (Printed) Degree/License

PATIENT AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____ do hereby authorize _____ to release and exchange medical/psychiatric and psychological information pertaining to me/my child with my primary care physician and my psychiatrist. This authorization is for the exchange of information between the PCP, psychiatrist, and behavioral health clinician and vice versa. This information will include information concerning social history, diagnosis, treatment plan, tests and medications. This authorization will expire no later than one year from the date of signature.

_____ _____

Signature: Date:

NOTICE TO RECIPIENT: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR, Part 2) and/or state law. I accordance with Federal and State law requirements, the information received pursuant to this document is confidential and recipient is prohibited from making further re-disclosure of this information to any other person or entity, or to use it for any purpose other than as authorized herein, without the written consent of the person to whom it pertains or as otherwise permitted by law. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

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TELEMENTAL HEALTH INFORMED CONSENT

I _____, (name of client) hereby consent to participate in telemental health with _____ (name of provider) as part of my psychotherapy. I understand that telemental health is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are located in two different locations.

I understand the following with respect to telemental health:

1. I understand that I have the right to withdraw consent at any time without affecting my right to future care,services, or program benefits to which I would otherwise be entitled.
2. I understand that there are risk and consequences associated with telemental health, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.
3. I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.
4. I understand that the privacy laws that protect the confidentiality of my protected health information (PHI)also apply to telemental health unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).
5. I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telemental health services are not appropriate and a higher level of care is required.
6. I understand that during a telemental health session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to reconnect within ten minutes, please call me at _____ to discuss since we may have to re-schedule.
7. I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in case of an emergency.

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Emergency Protocols

I need to know your location in case of an emergency. You agree to inform me of the address where you are at the beginning of each session. I also need a contact person who I may contact on your behalf in a life-threatening emergency only.

This person will only be contacted to go to your location or take you to the hospital in the event of an emergency.

In case of an emergency, my location is: _____

and my emergency contact person's name, address, phone: _____

_____

I have read the information provided above and discussed it with my therapist. I understand the information contained in this form and all of my questions have been answered to my satisfaction.

Signature of Client / Parent / Legal Guardian: _____

Date: _____

Signature of Therapist: _____

Date: _____

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NOTICE OF PRIVACY PRACTICES AND BUSINESS POLICIES

We would like to welcome you to our office.
This document (the Agreement) contains important information about professional services and business policies, together with client/patient rights and responsibilities. Please read this required document in its entirety as you will be asked to sign it accordingly. It also contains summary information about HIPAA, the Health Insurance Portability and Accountability Act. When you sign this document, it will represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance on it or if you have not satisfied any financial obligations you have incurred.

COUNSELING (THERAPY PROCESS and SERVICES): Therapy is a relationship that works in part because of the clearly defined rights and responsibilities held by each person. This frame helps to create the safety to take risks and the support to facilitate and create change. Psychotherapy has both benefits and risks. Risks sometimes can include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness. Psychotherapy often requires discussing unpleasant aspects of your life. In time, this can lead to benefits for individuals who undertake it. Therapy can lead to a reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress, and resolutions to specific problems. There are however no guarantees about the outcome. Psychotherapy does require active effort on your part. In order to be most successful, you will have to work on things that we discuss outside of sessions. An initial evaluation is conducted. During that time, we will discuss if you would like to continue services and if this therapeutic relationship will be beneficial. Appropriate referrals will be made accordingly based on our decision at that time.

PROFESSIONAL RECORDS: We are required to keep appropriate records of the services provided. Although psychotherapy often includes discussions of sensitive and private information, in most cases brief records are kept noting that you have been here, what was done in session, and a mention of the topics discussed. Your records are maintained in a secure locked location and/or in an approved web-based behavioral health Practice Management System that has been chosen as having met security protocol standards set forth by HIPAA.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as **Protected Health Information = ("PHI")**.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

CONFIDENTIALITY: Sessions are confidential, and will be discussed with other people only with your written permission. Please note that confidentiality is limited in the case of a medical emergency, under a court order/ subpoena, or as required by law. In most situations, I can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA. There are, however, several exceptions in which 1 am legally bound to take action even though that requires revealing some information about a patient's treatment. If at all possible, 1 will make every attempt to inform you when such exceptions will have to be put into effect. The legal exceptions to confidentiality include, but are not limited, to the following:

For Treatment: Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment: We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will be done only with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance' benefits processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection services due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Options: We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to quality 'assessment activities, employee review activities, licensing and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g. billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI will be disclosed only with your authorization.

Required by Law: Under the law, we must make disclosures of your PHI to you upon request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

1. If there is good reason to believe that you are threatening to harm yourself or others. In this event I am required to seek hospitalization for you and/or contact the police, as well as additional means to provide protection.
2. If there is good reason to suspect, or evidence of, abuse and/or neglect toward children, the elderly or disabled persons. In such a situation, I am required by law to file a report with the appropriate state agency.
3. In response to a court order or where otherwise required by law.
4. To the extent necessary, to make a claim on a delinquent account via a collection agency.
5. To the extent necessary for emergency medical care to be rendered.

Please note there are times when I find it beneficial to consult with colleagues as part of my practice for mutual professional consultation. Your name and unique identifying characteristics will not be disclosed. The consultant is also legally bound to keep the information confidential.

Insurance and/or Managed Care:
If you will be using your behavioral health insurance benefits, we will discuss with you the sessions covered, your co-payment contract, and any additional paperwork required by your insurance company. Please be aware that most managed care companies offer a limited number of sessions and we will discuss with you how to best utilize these sessions. Please note that insurance companies will require that we release certain protected health information to them, including the diagnosis, treatment plan, and progress. Even though your policy may allow for a certain number of sessions per year, your managed care company may require that the sessions be approved in advance and they will review and approve a specific number of sessions as deemed "medically necessary." The therapist is to identify and/or treat an illness that has been diagnosed. Treatment under your insurance company is for the purpose of helping the client return to an overall good level of functioning, and is not for continued "growth therapy".

Verbal Permission:
We may use or disclose information to family members that are directly in your treatment with your verbal permission.

Written Authorization:
Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

Patient Rights:
You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to your therapist at 52 Brigham Street, Suite #5, New Bedford, MA 02740:

1. Right of Access to Inspect a copy. You have the right, which may be restricted to copy PHI that may be used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause harm to you. We may charge reasonable, cost-based fee for copies.
2. Right to Amend. If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information, although we are not required to agree to the amendment.
3. Right to an Accounting Disclosures. You have the right to request an accounting of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
4. Right to Request Restrictions: You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request.
5. Right to Request Confidential Communication. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.
6. Right to a Copy of this Notice. You have a right to a copy of this notice.

SOCIAL MEDIA & PUBLIC EVENTS POLICY: As part of our professional relationship, clear boundaries will be maintained as follows:

INTERNET SOCIAL MEDIA: There will be no connection created on any Internet social media account such as Facebook, LinkedIn, etc. Email is limited and will only be utilized for appointment changes or minimal information exchange. The only E-mail server utilized will be via my practice secure web portal or my encrypted E-mail account. This is strictly for your privacy and protection. E-mail is not to be utilized for emergencies.

Text Messaging is not accepted by this practice as appropriate for secure information exchange.

SOCIAL/PUBLIC EVENTS: If we encounter each other in the community at large, as your therapist I will not acknowledge that 1 know you. 1 am bound to keep our professional relationship confidential; therefore I will not initiate contact in public. You are free to initiate contact with your therapist. By signing this document, I acknowledge that I have read the above Agreement of Understanding and give Informed Consent to treatment services as well as agree to the policies set forth in the Agreement. I also acknowledge that I have had the opportunity to read the separate Privacy Practices/HIPAA disclosure and that I may ask for printed copies of these forms. If treatment involves your minor child, you as parent/guardian give consent and agreement to services for your child as set forth in this Agreement

COMPLAINTS: If you believe we have violated your privacy rights, you have the right to file a complaint in writing to your therapist at 52 Brigham Street, Suite 5, New Bedford, MA 02740, or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. or by calling (202) 619-0257. We will not retaliate against you for filing a complaint.

I acknowledge that I have had the opportunity to read these Privacy Practices/HI PM disclosures.

Your signature is your acknowledgment of having been informed of these policies;

_____ _____/_____/_____

Client Signature (*if minor* Parent, or Legal Guardian) **Date**

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PATIENT HEALTH QUESTIONNAIRE (PHQ-SADS)

This questionnaire is an important part of providing you with the best health care possible. Your answers will help in understanding problems that you may have. Please answer every question to the best of your ability.

A **During the last 4 weeks, how much have you been bothered by any of the following problems?**

	Not Bothered (0)	Bothered a little (1)	Bothered a lot (2)
1. Stomach pain	☐	☐	☐
2. Back pain	☐	☐	☐
3. Pain in your arms, legs, or joints (knees, hips, etc.)	☐	☐	☐
4. Feeling tired or having little energy	☐	☐	☐
5. Trouble falling or staying asleep, or sleeping too much	☐	☐	☐
6. Menstrual cramps or other problems with your periods	☐	☐	☐
7. Pain or problems during sexual intercourse	☐	☐	☐
8. Headaches	☐	☐	☐
9. Chest pain	☐	☐	☐
10. Dizziness	☐	☐	☐
11. Fainting spells	☐	☐	☐
12. Feeling your heart pound or race	☐	☐	☐
13. Shortness of breath	☐	☐	☐
14. Constipation, loose bowels, or diarrhea	☐	☐	☐
15. Nausea, gas, or indigestion	☐	☐	☐

PHQ-15 Score ☐ = _____ + _____

B **Over the last 2 weeks, how often have you been bothered by any of the following problems?**

	Not at all (0)	Several days (1)	More than half the days (2)	Nearly every day (3)
1. Feeling nervous anxiety or on edge	☐	☐	☐	☐
2. Not being able to stop or control worrying	☐	☐	☐	☐
3. Worrying too much about different things	☐	☐	☐	☐
4. Trouble relaxing	☐	☐	☐	☐
5. Being so restless that it is hard to sit still	☐	☐	☐	☐
6. Becoming easily annoyed or irritable	☐	☐	☐	☐
7. Feeling afraid as if something awful might happen	☐	☐	☐	☐

GAD-7 Score ☐ = _____ + _____ + _____

C **Questions about anxiety attacks.**

	NO	YES
1. In the last 4 weeks, have you had an anxiety attack — suddenly feeling fear or panic?	☐	☐

⚠ If you checked "NO", go to question **D**

2. Has this ever happened before?	☐	☐
3. Do some of these attacks come suddenly out of the blue that is, in situations where you don't expect to be nervous or uncomfortable?	☐	☐
4. Do these attacks bother you a lot or are you worried about having another attack?	☐	☐
5. During your last bad anxiety attack, did you have symptoms like shortness of breath, sweating, or your heart racing, pounding or skipping?	☐	☐

D **Over the last 2 weeks, how often have you been bothered by any of the following problems?**

	Not at all (0)	Several days (1)	More than half the days (2)	Nearly every day (3)
1. Little interest or pleasure in doing things	☐	☐	☐	☐
2. Feeling down, depressed, or hopeless	☐	☐	☐	☐
3. Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
4. Feeling tired or having little energy	☐	☐	☐	☐
5. Poor appetite or overeating	☐	☐	☐	☐
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
7. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual?	☐	☐	☐	☐
9. Thoughts that you would be better off dead of or hurting yourself in some way	☐	☐	☐	☐

PHQ-9 Score ☐ = ____ + ____ + ____

E **If you checked off any problems on this questionnaire, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?**

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐