Obert Associates

PATIENT INTAKE FORM – NEW PATIENT

Patient Name
Street Address
Mailing Address
City
State Zip Code
Gender M or F
May I call you at any of the above numbers? Y or N
Primary Care Physician (PCP)
PCP Address
Are you a full-time student? Y or N What school?
Are you seeing another therapist for mental health services? Y or N

Home Phone
Cell Phone
Work Phone
Email
Date of Birth
Marital Status: S M D W
May I leave a message at this email address? Y or N
PCP Office Phone

PRIMARY RESPONSIBLE PARTY

(This is the person responsible for paying any balances not covered by your insurance company.)

Name
Mailing Address
City
State Zip Code
Phone

SECONDARY RESPONSIBLE PARTY

Name
Mailing Address
City
State Zip Code
Phone

PRIMARY INSURANCE INFORMATION

Insurance Company
Insurance ID#
Group #
Mailing Address
City, State, Zip
Phone
Subscriber's Name
Subscriber's Date of Birth
Subscriber's Employer
Relation to Patient
Copayment Amount $
Do you have any form of MassHealth? Y or N If yes, MassHealth ID#

SECONDARY INSURANCE INFORMATION

Insurance Company
Insurance ID#
Group #
Mailing Address
City, State, Zip
Phone
Subscriber's Name
Subscriber's Date of Birth
Subscriber's Employer
Relation to Patient
Copayment Amount $

FOR OFFICE USE ONLY (To be filled out by the provider.)

DIAGNOSIS CODE(S):

1. 2.

3. 4.

SIGNATURE DATE:

Obert Associates

New Patient - Patient Consent and Authorization

Consent to Treatment: _____**Initials**

I hereby consent to receive mental health treatment from Keith Obert of Obert Associates (hereafter referred to as Obert Assoc.). I understand that my consent is voluntary. I also understand that I do not have to accept any treatment option Obert Assoc. offers and that I may withdraw my consent at any time.

I accept that working toward change may involve experiencing difficult and intense feelings, some of which may be painful, in order to reach therapy goals. I understand that the changes I make will have an impact on my partner and on others around me. I accept that such changes can have both positive and negative effects and agree to clarify and evaluate potential effects of changes before undertaking them. [This is especially true if dependent children are involved] On the other hand, therapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reduction in feelings of distress.

Treatment Sessions: _____**Initials**

I understand that standard treatment sessions are 50 minutes in length, but that exceptions may occur.

I also understand that there are circumstances in which individual therapy alone may not be the best treatment option. Such circumstances may include when there is active substance abuse, domestic violence or emotional abuse that are not stable and/or untreated. I further understand that Obert Assoc. may choose at any time to discontinue services in the event that any of these circumstances are present, and at such time all fees paid to Obert Assoc. to date, regardless of duration of treatment, are nonrefundable. I understand that in such circumstances, Obert Assoc. will make a good faith effort to provide me with alternative referrals for treatment, but that ultimately it is my responsibility to seek out and pursue treatment.

Joint Therapy Session and Release of Medical Records _____**Initials**

I understand in order for any therapy information or medical records to be released, all members of a joint therapy session must provide written authorization. If some individual sessions may help the process of family therapy or joint therapy, what I say in those individual sessions will be considered to be a part of the medial record.

I also understand that information discussed in joint therapy is for therapeutic purposes and is not intended for use in any legal proceedings involving the individual(s). I agree not to subpoena my therapist to testify for or against any parties or to provide records in a court action.

Confidentiality: _____**Initials**

I understand that our communications are private and protected by law. Because of laws protecting confidentiality, I most situations my therapist cannot share information about our work without my permission. However, there are certain specific limits to confidentiality. I fully understand these limits below.

1. In order for Obert Assoc. to function, my therapist may share some of my protected information with staff for purposes such as scheduling and billing. All administrative staff are trained to protect my privacy and have agreed to be bound by the rules of confidentiality.
2. Obert Assoc. has a contract with a billing service. As required by HIPAA, Obert Assoc. has a formal business associate contract with this business, in which it promises to maintain the confidentiality of data except as specifically allowed in the contract or otherwise required by law.
3. There may be times during our work when, in order to support progress toward my goals, my therapist will consult with a colleague or supervisor. My therapist will do this in a way that minimizes identifying information. All mental health professionals with whom my therapist consults are bound by the rules of confidentiality.
4. If I am using my health insurance, I consent that my insurance company can receive certain information about our work. This information usually includes a diagnosis, treatment goals, and a plan for achieving those goals. My therapist cannot refuse to provide this information to my insurance company. If I wish, I may choose to pay privately for treatment in order to avoid any disclosure to my insurance company.
5. Generally, if I am involved in legal proceedings, my therapist cannot provide any information about our work without my permission. There are exceptions an, if I anticipate being involved in litigation, I should consult my attorney to determine whether a court could order my therapist to disclose information.
6. If I file a complaint or lawsuit against my therapist, my therapist may disclose relevant information pertaining to me in order to defend himself/herself.
7. If, in the course of our work, my therapist has reasonable cause to believe that any child under the age of 18 is being (or has been) physically or emotionally harmed in any way (either because of abuse—including sexual abuse—or neglect) the law REQUIRES my therapist to file a report with the Massachusetts Department of Children and Families. My therapist will inform me if he/she finds that he/she must file a report.
8. Similarly, if my therapist has reasonable cause to believe that an elderly person (age 59 or older) or a handicapped person of any age is (or has been) suffering from abuse, the law REQUIRES that my therapist file a report with the appropriate authorities.
9. Finally, if I let my therapist know that I intend to harm myself or intend to harm another person and my therapist believes the risk is real, my therapist may be REQUIRED to break confidentiality by contacting the police, alerting the intended victim, contacting a family member, and/or seeking my hospitalization without my consent.

Communication and Availability: _____**Initials**

Due to my therapist's work schedule, my therapist is often not immediately available by telephone. When my therapist is unavailable, an automated voice mail answers his telephone. My therapist will make every effort to return my call on the same day I make it, with the exception of weekends and holidays. If I will be difficult to reach, I will inform my therapist of some times when I will be available. In a life-threatening emergency, I will call 911 or go to the nearest Emergency Room.

I understand that email is not a secure medium for communication and my therapist's preference is that I contact him/her by phone. However, if I choose to contact my therapist using email, I am doing so with the full understanding that my therapist cannot guarantee the safety and security of that communication, despite Obert Assoc. taking all possible action to protect my privacy. I also acknowledge that email occasionally disappears or is delayed and that my therapist may never receive an email that I send. For example, canceling a session via email is NOT an appropriate method of notification. My therapist recommends that in order to give adequate 24-hour notice of such cancellations, I do so by phone.

Financial Obligation: _____**Initials**

I understand that I am responsible for full payment of al fees for services provided by Obert Assoc. regardless of whether there is insurance coverage. If I have insurance, I understand that I am responsible for knowing the specific terms and limits of my insurance coverage, and that I am ultimately responsible for full payment of fees. Furthermore, unless prior arrangements are made, I agree to pay any self-pay fees, copayments, and/or coinsurance amounts at the beginning of each session.

Assignment of Benefits and release of Information: _____**Initials**

I hereby assign and transfer over to Obert Assoc., all of my rights, title and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine benefits, including medical, psychiatric and/or substance abuse (drug or alcohol) information. This authorization shall remain in effect until written notice is given by me revoking this authorization. I certify that the information given is correct. I understand that this assignment and authorization does not relieve me of my obligation to pay any bills not covered by my insurance policy. I agree to pay any balance due in full no later than 30 days of statement, unless other arrangements have been made in advance.

ACKNOWLEDGEMENT

My initials above and signature below acknowledge that I understand and accept the terms and conditions of this authorization and agreement. If the patient is a minor child, an appropriate guardian must sign below. Such signature acknowledges that this authorization and agreement applies to the minor child.

Signature:_____**Date:**_____

Relationship to patient if signed by parent/guardian:_____

Obert Associates

CANCELLATION AND ATTENDANCE POLICY

Cancellation Policy: _____**Initials**

If I am unable to keep an appointment, I agree to notify Obert, Assoc. at least 24 hours in advance of my scheduled visit.

I understand that **I WILL BE CHARGED** the full session rate for all sessions cancelled with less than 24 hour notice. I also understand that this **FEE IS NOT COVERED BY INSURANCE**.

Attendance Policy: Initials

Obert Assoc. recognizes that circumstances arise when I might need to miss more than one appointment during the course of a month. Obert Assoc. is able to hold my designated slot as a courtesy for up to (4) four weeks.

If I miss more than one appointment within one more for any reason, I will be charged a $50 fee (per week) so that my slot can be held.

Note: This fee will be charged regardless of advanced notice duration. Obert Assoc. cannot offer this benefit for more than 4 week.

Additionally, a signed credit card release form must be on file OR I will need to pay for the reserved sessions in advance. Failure to do so will result in my slot no longer being held in reserve for me.

ACKNOWLEDGEMENT

My initials above and signature below acknowledge that I understand and accept the terms and conditions of this policy. If the patient is a minor child, an appropriate guardian must sign below. Such signature acknowledges that this authorization and agreement applies to the minor child.

Signature:_____**Date:**_____

Relationship to patient if signed by parent/guardian:_____

Obert Associates

NOTICE OF PRIVACY PRACTICES

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 REVIEW IT CAREFULLY.

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 your consent. To help clarify these terms, here are some definitions:

- "PHI" refers to information in your health record 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 family physician or another psychologist.
    - Payment is when I obtain reimbursement for your health care. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your 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 care coordination.
- "Use" applies only to activities within my office, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "Disclosure" applies to activities outside of my office, such as releasing, transferring, or providing access to information about you to other parties.

After you have read this notice you will be asked to sign a form indicating receipt of this notice as well as a separate Consent form to allow me to use and share your PHI. In almost all cases I intend to use your PHI here in my office or share your PHI with other people or organizations to provide **treatment** to you, arrange for **payment** for my services, or health care **operations**.

Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, or 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, or health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization 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 medical record. These notes are given a greater degree of protection.
- Use or disclosure of your protected health information for marketing purposes.

You may revoke all such authorization (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

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 the ordinary course of my profession, have reasonable cause to suspect or believe that any child under the age of eighteen years (1) has been abused or neglected, (2) has had nonaccidental physical injury, or injury which is at variance with the history given of such injury, inflicted upon such child, or (3) is placed at imminent risk of serious harm, then I must report this suspicion or belief to the appropriate authority.
- *Adult and Domestic Abuse* – If I know or in good faith suspect that an elderly individual or an individual who is disabled or incompetent has been abused, I may disclose the appropriate information
- *Health Oversight Activities* – If a government agency is investigation my practice, I have to disclose some information.
- *Judicial and Administrative proceedings* – There are some federal, state, or local laws which require me to disclose PHI.
    - **i.** If you are involved in a lawsuit or legal proceeding and I receive a subpoena, discovery request, or other lawful process I may have to release some of your PHI. I will only do so after trying to inform you of the request, consulting your lawyer, or trying to obtain a court order to protect the requested information.
    - **ii.** If you bring a lawsuit against me and disclosure is necessary or relevant to a defense, I may disclose the appropriate information.
- *Serious Threat to Health or Safety* – If I believe in good faith that there is risk of imminent personal injury to yourself or to other individuals or risk of imminent injury to the property of other individuals, I may disclose the appropriate information. I may also disclose PHI if it is necessary for you to be hospitalized for psychiatric care.
- *Worker's Compensation* – I may disclose PHI regarding you as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

Patient's Rights and Therapist'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 at 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 and psychotherapy notes 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 this decision reviewed. On your request, I will discuss with you the details of the request and denial 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 above in 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 in full for my services.
- *Right to Be Notified if There is a Breach of Your Unsecured PHI*. You have the 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.

Therapist'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 this 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 you in person, via mail, or via another method agreed upon in advance

Questions and Complaints

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact me at (978) 502-9166 for additional information. If you believe that your privacy rights have been violated and wish to file a complaint with me, you may send your written complaint to our office at Obert Associates, 33 Stone Road, Shelburne Falls, MA 01370-9770, Attn: Security. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. Our office can provide you with the appropriate address upon request. You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

Other Uses of PHI in Healthcare

- Business Associates – There are some jobs I hire other businesses to do for you. In the law, they are called Business Associates. Examples may include a copy service to make copies of your health records or a billing service to print, mail, and follow-up on my insurance claims for reimbursement, to mail patient bills, and/or to contact your insurance company regarding benefits, eligibility, and authorization. These business associates need to receive some of your contract to safeguard your information.

Effective Date of this notice June 1, 2015

Obert Associates

NOTICE OF PRIVACY PRACTICES

Patient Name

Patient Date of Birth

THE SIGNATURE BELOW INDICATES THAT I HAVE RECEIVED A COPY OF THE NOTICE OF PRIVACY PRACTICES FROM KEITH OBERT OF OBERT ASSOCIATES:

Signature of Patient or Guardian **Date**

Parent or Guardian's Name *(Please Print)* **Relationship to Patient**

Obert Associates

CREDIT CARD PROCESSING FORM

Obert Associates and its Billing Agency* are authorized to keep my signature on file and charge my account for any balances due from Obert Associates services rendered to me or my family not covered by my insurance plan. I understand that this authorization will remain in effect until Obert Associates has received written notification from me of its termination in such time and manner to afford Obert Associates a reasonable opportunity to act upon it.

Patient Name: _____

Cardholder (as it appears on card):_____

Billing Address :_____

_____

(Circle one) VISA MASTERCARD AMERICAN EXPRESS DISCOVER

Credit Card Number:_____

Expiration Date:_____ CVV #_____
(3 digit security code from back of card)

Cardholder's Signature:_____

_____(***Please check if applicable***) I am also authorizing Obert Associates and its Billing Agency to use the above listed credit card for my spouse/partner/family member for all balances on their account as well. I know that this is in addition to the balances on my account. My signature above authorizes Obert Associates to apply balances from my spouse/partner/family member's account although my spouse/partner/family member's name is not on the credit card being used at this time.

Print Spouse/Partner/Family Member's Name_____

Signature of Spouse/Partner/Family Member_____

*This authorization shall also apply to our billing agency that is covered under a confidentiality agreement with Obert Associates as well as a HIPAA Business Associates Agreement.

Please note that Obert Associates shall keep the above information confidential. Obert Associates shall use all reasonable efforts to preserve the secrecy and confidentiality of the above information. Obert Associates shall not disclose such confidential information to any third party outside of Obert Associates' practice.

Effective June 1, 2015 Signature of Obert Associates Credit Card Processing Form is required of all Obert Associates clients.