NEW PATIENT INFORMATION PACKET

Please fill out and bring with you at your appointment on: _____at _____ .

Patient Information

First Name _____ Middle Initial _____ Gender **M F**

Last Name _____

Mailing Address _____

City _____ State _____Zip Code _____

Home Phone ( ) _____ SSN _____

Work Phone ( ) _____ Birth Date _____

Employed by _____ Position _____

Very Important: Which of these telephone numbers may we use if we need to contact you? _____

AND In the event we need to contact you by telephone, who may we speak with or leave a message with, other than yourself? _____

How were you referred to this office? _____

Patient & Family Information

Marital Status ☐ Single ☐ Married ☐ Other

Employment Status ☐ Employed ☐Full-time Student ☐ Part-time Student

Employed by _____ Position _____

List Family Members/Significant Other Names: _____

_____

Insurance Information ***(Please bring proof of insurance to your appointment or you will be responsible for full payment at time of service. This section must be filled out completely or we cannot process your claim.)***

Patient's ID # _____ Insurance Company _____

Subscriber's SSN _____ (Subscriber is the person who holds the insurance policy.)

Subscriber's Last Name _____

Subscriber's First Name _____ Middle Initial _____

Patient Relationship to Subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other

Street Address _____

City _____ State _____Zip Code _____

Home Phone ( ) _____ Work Phone: ( ) _____

Subscriber's Birth Date _____ Subscriber's Employer _____

Emergency Contact _____ Emergency Contact Phone ( ) _____

Relationship _____

Primary Care Physician

Name of family physician _____

Name of Practice _____

Street Address _____

City _____ State _____Zip Code _____

Work Phone ( )_____ Date of last visit _____

Referral Source Information (If a Professional)

Name of family physician _____

Name of Practice _____

Street Address _____

City _____ State _____Zip Code _____

Work Phone ( )_____ Date of last visit _____

I hereby authorize Arlene Brewster to release any billing information to "Party Responsible for Payment"
(Parent or Guardian signature if patient is a minor)

Patient's Signature _____ Date _____

Are you currently being treated for any medical illness? If yes, please describe. _____

_____

_____

_____

Have you ever been hospitalized for psychiatric reasons? If yes, please list dates and reasons. _____

_____

_____

_____

What medication(s) are you currently taking? _____

_____

_____

_____

Please list any medication(s) that you have taken in the past five years. _____

_____

_____

_____

Have you ever seen a Psychotherapist and/or a Psychiatrist before? If so, please list name(s) and date(s) of treatment. _____

_____

_____

Has anyone in your family had emotional or psychiatric problems? If yes, please describe. _____

_____

_____

_____

Provider – Patient Services Agreement

Welcome to my private practice. This document (the Agreement) contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a new federal law that provides new privacy protections and new patient rights with regard to the use and disclosure of your Protect Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) which you will receive with this agreement, for the use and disclosure of PHI for treatment, payment and health care operations. The Notice explains HIPAA and its application to your personal health information in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this information at the end of the first session. **Although these documents are long and sometimes complex, it is very important that you read them carefully before our first session.** We can discuss any questions you have about the procedures at that time. When you sign this document, it will also 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 already taken action in reliance on it; if there are obligations imposed on my by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

Psychological and Medical Services

During the first session or two, I will help you identify your goals for therapy. Psychotherapy has both benefits and risks. While it has been shown to have benefits for people who invest in the process with commitment and realistic expectations it also has risks that may include experiencing uncomfortable feelings or recalling unpleasant aspects of your history. These are common feelings when trying something new. Psychotherapy often leads to a significant reduction in feelings of distress, better relationships, and resolution of problems. However, I cannot guarantee any particular resolution to problems or a particular response to treatment.

If you have any questions about any procedures, it is important to discuss them with me whenever they arise. If your doubts persist or you are concerned that you and I are not suitably matched, an appropriate consultation with another professional may be beneficial.

Emergency Contact

In the event of an emergency please contact me at (207) 439-2001. If you are experiencing a serious emergency and cannot wait for a return call from me, then please call the contact the Crisis Response Service at (888) 568-1110 or you should seek assistance at the local hospital emergency room. Please call me as soon as possible when you return.

Late Cancellation and Missed Appointments

Your appointment reserves my time. Once an appointment is scheduled, you will be expected to pay $50 if it is cancelled unless you provide **24 business hours** advance notice of cancellation. ***(For example, to cancel an appointment for 9am on Monday, you would need to call before 9am the previous Friday.)*** These charges cannot be billed to your insurance company. Please help me serve you better by keeping scheduled appointments and calling the office **at least 24 business hours** prior to your appointment if you must cancel.

Confidentiality

A. General

In order for therapy to be successful, it is often necessary to safely reveal private, sensitive information about yourself in the course of treatment. Ethically and legally, all of us here are bound to keep all of this information strictly confidential. The law protects the privacy of all communications between a patient and a clinical provider. 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 other situations that require only that you provide written, advance consent. Your signature on this Agreement provides consent for those activities as follows:

> I may occasionally find it helpful to consult with other health and mental health professionals about a case. During a consultation, I make every effort to avoid revealing the identify of my patient. The other professionals are also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together. I will note all consultations in your Clinical Record (which is called "PHI" in my Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information).
>
> You should be aware that I practice with other mental health professionals and that I employ administrative staff. In most cases,, I need to share protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing, and quality assurance. All of the mental health professionals are bound by the same rules of confidentiality.
>
> Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.

There are certain conditions under which confidentiality may be breached. These breaches conform to the American Psychology Association and Maine's code of ethics for psychologists.

- If a patient threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her, or to contact family members or others who can help provide protection.
- If you disclose that a child or an elderly person is being sexually or physically abused, it must be reported to the proper authorities.
- If you are a danger to yourself or someone else, I must do whatever is necessary to protect you and/or the other person. The other person would have to be warned and the police notified.
- In legal proceedings, the courts usually respect your rights to confidentiality in the therapeutic relationship, and I am ethically bound to protect that right when testifying in legal or administrative proceedings. However, a judge could court order me to testify in certain situations, such as a contested custody proceeding in a divorce and, under these circumstances, I must do so.
- If a government agency is requesting the information for health oversight activities, I may be required to provide it.
- If a patient files a lawsuit against me, I may disclose relevant information regarding the patient in order to defend myself.

It is our practice, whenever possible, to discuss any imminent breaches of confidentiality with you before taking any action and I will limit my disclosure to the minimum necessary.

B. Professional Records and Patient Rights

The laws and standards of my profession require that I keep Protected Health Information (PHI) about you in your Clinical Record. HIPAA provides you with several new or expanded rights with regard to your Clinical Records and disclosures of protected health information. These rights include requesting that I amend you record; requesting restrictions on what information from your Clinical Records is disclosed to others; requested an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the Notice form, and my privacy policies and procedures. You may examine and/or receive a copy of your Clinical Record, if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them in my presence, or have them forwarded to another mental health professional so you can discuss the contents. In most circumstances, I am allowed to charge a copying fee of $15.00 for the first 30 pages or 50 cents per page, whichever is greater.

C. Couples and Families

When there is more than one person involved in treatment, such as in couples and family therapy, confidentiality is more complicated. In these cases, the unit is defined as the couple or the family. Usually, and unless otherwise specified, information that is shared by a member of the unit within the context of that therapy cannot be considered confidential from the other parties involved in the therapy. To ask me to keep secrets from other members of the therapy can disrupt the trust necessary for an effective treatment. Also, to release information to third parties under such circumstances, all person age 18 and over involved in treatment must consent in writing to that release.

D. Group Therapy

In group therapy, any and all information shared within the group sessions by any group member must be kept confidential consistent with the limits to confidentiality listed on pages 5 and 6 above.

E. Office Policies

All support staff are bound to confidentiality and cannot disclose any information.

Insurance Reimbursement and Patient Balances

My practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. I accept assignment of insurance benefits from most insurance companies for your primary insurance only. However**, I do require that deductibles and co-payments be paid in full at the time of service**. The balance is your responsibility whether your insurance company pays me or not. Your insurance policy is a contract between you and your insurance company and I am not a party to that contract. If your insurance company has not paid your account in full within 60 days, the balance automatically becomes your responsibility. Please be aware that in some cases the services provided may be considered non-covered services by your insurance plan. Delinquent accounts must be paid in full before another session can be scheduled. Delinquent accounts may require further action.

You should carefully read the section in your insurance coverage booklet that describes mental health services. Your coverage, co-payments, and benefits could be quite different from your regular medical coverage. If your insurance plan includes a managed care component, you may be required to obtain preauthorization and your

coverage may be limited. It is your responsibility to contact your insurance company to determine if preauthorization must be obtained by you prior to your treatment.

You should also be aware that most insurance agreements require you to authorize me to provide basic clinical information such as diagnosis and treatment plans. Occasionally an entire copied record is required. While it is my policy to release only the minimum necessary information required to activate your insurance benefits, you need to be aware that I cannot control its use by your insurance company. Any concerns you may have about confidentiality of managed care records should be directed to the managed care company.

Some insurance companies require that I send billing and other information electronically (e.g., by facsimile or e-mail). The confidentiality of such communications cannot be guaranteed. If you do not consent to electronic communications, please inform me immediately, before beginning treatment, so that I can determine whether and how to proceed. Once information about your insurance coverage has been determined, it is important for you to discuss with me what can be accomplished with the benefits that are available, and what will happen should your benefits expire before you feel ready to end treatment. It is important to remember that you always have the right to pay for services yourself and not involve your health insurer at all.

Cost of Services

Initial Evaluation	$130
Individual Psychotherapy Session, 50 minutes	$120
Family/Couple Psychotherapy Session, 50 minutes	$125
Appointment missed without 24 hours notice	$50

I bill at $150 per hour for ancillary services such as preparing for and participating in legal matters relating to your treatment. A retainer, in advance, is required prior to undertaking such services. By signing this form you agree to pay for such services when you request them.

In Closing

It is important that you understand and are comfortable with the issues outlined above. Please bring up, in your first treatment session, any questions or concerns you might have.

Please Sign

Name of Patient _____

I have read and accept the terms outlined on pages 4, 5, 6, and 7 above.

_____ _____

Signature of patient or legal representative Date

_____ _____

Signature of patient or legal representative Date

I have reviewed the Mental Health Bill of Rights and the Notice of Psychologists' Policies and Practices to Protect the Privacy of Your Health Information.

_____ _____

Signature of patient or legal representative Date

_____ _____

Signature of patient or legal representative Date

I have reviewed the Notice of Psychologists' Policies and Practices to Protect the Privacy of Your Health Information.

_____ _____

Signature of patient or legal representative Date

_____ _____

Signature of patient or legal representative Date

CONSENT TO RELEASE INFORMATION

I authorize Arlene Brewster to release and exchange medical information as necessary to my insurance carrier, my primary care physician, and a referring physician or therapist.

I understand I am responsible for contacting my insurance company for benefit coverage and preauthorization (if needed) prior to the day of treatment. I will provide this information to Arlene Brewster's office (the Office) at the time of my first appointment. I will provide current information regarding my insurance throughout my course of treatment.

I understand that my insurance will be billed by the Office with the proper information provided.

I understand that this does not guarantee insurance payment to Arlene Brewster and that any outstanding balance is my responsibility.

I understand that regardless of insurance coverage, I must settle my account within sixty (60) days.

I further understand that I may revoke this authorization at any time should I desire by notifying the Office in writing.

Name of Patient _____

_____ _____

Signature of patient or legal representative Date

_____ _____

Arlene Brewster, Ph.D. Date

Receipt of HIPAA Notification and Bill of Rights _____Date: _____

SECONDARY INSURANCE INFORMATION

INERNAL USE ONLY

Date received by office: _____

Primary Insurance _____

Effective Date of Insurance _____

Secondary Insurance _____

Effective Date of Insurance _____

Insurance Information ***(Please bring proof of insurance to your appointment or you will be responsible for full payment at time of service. This section must be filled out completely or we cannot process your claim.)***

Patient's ID # _____ Insurance Company _____

Subscriber's SSN _____ (Subscriber is the person who holds the insurance policy.)

Subscriber's Last Name _____

Subscriber's First Name _____ Middle Initial _____

Patient Relationship to Subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other

Street Address _____

City _____ State _____Zip Code _____

Home Phone ( ) _____ Work Phone: ( )_____

Subscriber's Birth Date _____ Subscriber's Employer _____

CHECKING INSURANCE COVERAGE

Please use these questions as a guide when contacting your insurance provider to check on your coverage.

Have this information ready when you call:

Date _____

Patient's Name _____ SSN or ID# _____

Insurance Company _____ Telephone # _____

Person you spoke to _____

"I'm calling to check on my behavioral health benefits for a new patient and if authorization is needed."

What is the co-pay amount? _____

Is there a deductible _____ Has it been met? _____

Are the benefits calendar year or plan year? _____ Is authorization needed? ☐ Yes ☐ No

If yes, "I am calling to get one."

Authorization # _____

Effective Date _____

Are there a maximum number of visits? ☐ Yes ☐ No If yes, how many? _____

Do medication checks count against the total number of mental health visits? ☐ Yes ☐ No

What is the claims mailing address?

Street Address _____

City _____ State _____Zip Code _____