NEW PATIENT INFORMATION PACKET

Please fill out this packet then mail it to Arlene Brewster.

Address:
7 Bond Road
Kittery Point, ME 03905

Patient Information

First Name: ________________________________ Middle Initial ________

Last Name: ______________________________ Birth Date ______/______/______

Mailing Address ____

City ____________________ State ________________ Zip Code ________________

Email Address ____

Home Phone ________________________ Work Phone ________________________

Cell Phone ________________________

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

Home Phone Work Phone Cell Phone

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 Others Names ____

____

Emergency Contact ____

Emergency Contact Phone ______________________________ Relationship ____________________

Primary Care Physician

Name of Physician ____

Name of Practice ____

Street Address ____

City ____________________ State _______________ Zip Code _______________

Phone Number ______________________________ Date of Last Visit ______/_______/_______

Referral Source Information (If a Professional)

Name of Physician ____

Name of Practice ____

Street Address ____

City ____________________ State _______________ Zip Code _______________

Phone Number ______________________________ Date of Last Visit ______/_______/_______

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 healthcare 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 me 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 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 $75 if it is canceled 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. Please help me service 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 identity 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 on 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 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 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 your 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 persons 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 session by any group member must be kept confidential consistent with the limits to confidentiality listed on page 5 and 6 above.

E. Office Policies

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

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 (printed) ____

I have read and accept the terms outlined on pages 4, 5, and 6 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 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 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 Date

____ ________________________
Arlene Brewster, Ph.D. Date

Receipt of HIPAA Notification and Bill of Rights __________________________ Date: _____________

Mental Health Bill of Rights

This Mental Health Bill of Rights is provided by law to persons receiving mental health services in the States of Maine and New Hampshire. Its purpose is to protect the rights and enhance the well being of clients, by informing them of key aspects of the clinical relationship. As a client of a Maine or New Hampshire Mental Health Practitioner, you have, without asking, the right:

(1) To be treated in a professional, respectful, competent and ethical manner consistent with all applicable state laws and the following professional ethical standards:
  a. for psychologists, the American Psychological Association;
  b. for independent clinical social workers; the National Association of Social Workers;
  c. for pastoral psychotherapists; the American Association of Pastoral Counselors;
  d. for clinical mental health counselors; the American Mental Health Counselors Association; and
  e. for marriage and family therapists; the American Association for Marriage and Family Therapists.

(2) To receive full information about your treatment provider's knowledge, skills, experience and credentials.

(3) To have the information you disclose to your mental health provider kept confidential within the limits of state and federal law. Communications between mental health providers and clients are typically confidential, unless the law requires their disclosure. Mental health providers will inform you of the legal exceptions to confidentiality, and should such an exception arise, will share only such information as required by law. Examples of such exceptions include but are not limited to:
  a. abuse of a child;
  b. abuse of an incapacitated adult;
  c. Health Information Portability and Accountability Act (HIPAA) regulation compliance;
  d. certain rights you may have waived when contracting for third party financial coverage;
  e. orders of the court; and
  f. significant threats to self, others or property.

(4) To a safe setting and to know that the services provided are effective and of a quality consistent with the standard of care within each profession and to know that sexual relations between a mental health provider and a client or former client are a violation of the law.

(5) To obtain information, as allowed by law, pertaining to the mental health provider's assessment, assessment procedures and mental health diagnoses.

(6) To participate meaningfully in the planning, implementation and termination or referral of your treatment.

(7) To document informed consent: to be informed of the risks and benefits of the proposed treatment, the risks and benefits of alternative treatments and the risks and benefits of no treatment. When obtaining informed consent for treatment for which safety and effectiveness have not been established, therapists will inform their clients of this and of the voluntary nature of their participation. In addition, clients have the right to be informed of their rights and responsibilities, and of the mental health provider's practice policies regarding confidentiality, office hours, fees, missed appointments, billing policies, electronic communications, managed care issues, record management, and other relevant matters except as otherwise provided by law.

(8) To obtain information regarding the provision(s) for emergency coverage.

(9) To receive a copy of your mental health record within 30 days upon written request (except as otherwise provided by law), by paying a nominal fee designed to defray the administrative costs of reproducing the record.

(10) To know that your mental health provider is licensed by the State of Maine or New Hampshire to provide mental health services.
  a. You have the right to obtain information about mental health practice in Maine or New Hampshire. You may contact the Board of Mental Health Practice for a list names, addresses, phone numbers and websites of state and national professional associations listed in Mhp 502.02(a)(1) (a-e).
  b. You have the right to discuss questions or concerns about the mental health services you receive with your provider.
  c. You have the right to file a complaint with the Maine Board of Examiners in Psychology or the New Hampshire Board of Mental Health Practice.

____
(Initials)

Maine Notice Form

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.

I. 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 healthcare. 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.
    - *Heath Care Operations* are activities that relate to the performance of 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, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- *"Disclosure"* applies to activities outside of my [office, clinic, practice group, etc.], such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosure 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 this information. I will also need to obtain an authorization before releasing your psychotherapy notes. "Psychotherapy notes" are notes I have made about our conversations 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 than PHI.
You may revoke all such authorizations (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, and the law provides the insurer the right to contest the claim under the policy.

III. 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 have a reason to suspect that a child has been abused or neglected, I am required by law to report this to the Bureau of Child and Family Services.
- **Adult and Domestic Abuse:** If I suspect or have a good faith reason to believe that any incapacitated adult has been subject to abuse, neglect, self neglect or exploitation, or is living in hazardous conditions, I am required by law to report that information to the Commissioner of the Department of Health and Human Services.
- **Health Oversight:** If the Maine Board of Examiners in Psychology is conducting an investigation, then I am required to disclose your mental health records upon receipt of a subpoena from the Board.
- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about the professional services that I provided you and/or the records thereof, such information is privileged under state law, and I may not release information without your written authorization, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court-ordered. You will be informed in advance, if this is the case.

____
(Initials)

CREDIT CARD AUTHORIZATION

I, ____, authorize Arlene Brewster to charge my credit card for the following:

$190 for all individual or couples sessions

$75 for any appointment missed or canceled with less than 24 hours' notice

Name Printed on Card: ____

Type of Card: ☐ Visa ☐ Master Card ☐ Discover ☐ AmEx ☐ Other

Credit Card Number: _____________ -_____________ -_____________ -_____________

Expiration Date: _______/_______ CVC 3- or 4-Digit Code: ______________________

Billing Address Zip Code: ______________

By signing below, I certify that the above information is true and accurate and that I am an authorized user on the credit card account above. I authorize Arlene Brewster to keep my credit card information on file and charge the above fees until treatment ends. Arlene Brewster will destroy credit card information when treatment ends. I understand that I am responsible for notifying Arlene Brewster if my credit card information needs to be updated. Arlene Brewster agrees to only charge for services rendered or for appointments not canceled 24 hours in advance. I understand that if I wish to cancel an appointment I will need to send an email to Arlene Brewster (arlbrew@yahoo.com), or leave a recorded voicemail message at (207)-439-4001.

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Signature