PORTSMOUTH
and
EXETER MENTAL HEALTH ASSOCIATES, INC.
500 Market Street, 1-G
Portsmouth, NH 03801

Voice - (603) 433-2656
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PLEASE FILL OUT IN FULL AND BRING WITH YOU AT YOUR APPOINTMENT ON _____ AT _____

DATE_____Dx_____

PATIENT INFORMATION SHEET

LAST NAME _____

FIRST_____MIDDLE_____

STREET_____ APT. NO._____

CITY_____ STATE _____ ZIP_____

HOME PHONE _____ WORK _____

DATE OF BIRTH _____

PATIENT'S EMPLOYER _____

BUSINESS ADDRESS _____

NEXT OF KIN _____

ADDRESS_____TEL NO_____

HOME PHONE _____ WORK PHONE _____

IF THIS CLIENT IS A CHILD: (Names & addresses of other legal guardians involved in the parenting of this child)

_____

_____

HEREBY AUTHORIZE P.E.M.H.A. to send a letter to the non-accompanying legal guardian notifying them that their child has been referred for treatment.

_____

(signature of accompanying guardian)

PARTY REPSONSIBLE FOR PAYMENT_____

(please do not list insurance company)

ADDRESS _____

HOME PHONE _____ WORK PHONE _____

I HEREBY AUTHORIZE P.E.M.H.A. to release any billing information to "party responsible for payment."

Patients Signature _____ Date _____

(Guardian/Parent's signature if a minor)

PLEASE LIST ALL MEMBERS OF YOUR HOUSEHOLD:

NAME **AGE** **RELATIONSHIP**

REFERRED BY

_____

NAME OF FAMILY PHYSICIAN

_____

ADDRESS _____ TEL NO _____

DATE OF LAST VISIT

_____

Do you (patient) want this office to contact your Primary Care Physician?

_____

IF YES, PLEASE COMPLETE RELEASE OF INFORMATION

ARE YOU CURRENTLY BEING TREATED FOR ANY MEDICAL ILLNESS? IF YES PLEASE DESCRIBE:

_____

_____

PLEASE LIST ANY MEDICATIONS THAT YOU HAVE TAKEN?

_____

_____

WHAT MEDICATION(s) ARE YOU CURRENTLY TAKING?

_____

_____

HAVE YOU EVER SEEN A PSYCHOTHERAPIST BEFORE? IF SO, PLEASE LIST THERAPIST ADDRESS AND DATE OF TREATMENT

_____

_____

HAS ANYONE IN YOUR FAMILY HAD EMOTIONAL DIFFICULTIES OR PSYCHIATRIC PROBLEMS?

_____

_____

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AUTHORIZATION TO RELEASE INFORMATION

I AUTHORIZE PORTSMOUTH/EXETER MENTAL HEALTH ASSOCIATES AND THOSE LISTED TO RELEASE MEDICAL INFORMATION NECESSARY TO BILL FOR AND SUBSTANTIATE.

_____

Name of Patient

PRIMARY INSURANCE CO. _____

SUBSCRIBER_____ EFF._____
(Employee's name)

SUBSCRIBER'S ADDRESS, IF DIFFERENT FROM PATIENT _____

_____

SUBSCRIBER'S EMPLOYER _____

CERTIFICATE/ID NO. _____ GROUP NO._____

SECONDARY INSUR. PLAN, IF AVAILABLE _____

SUBSCRIBER NAME _____

SUBSCRIBER'S ADDRESS, IF DIFFERENT FROM PATIENT _____

_____

CERTIFICATE/ID NO. _____ GROUP NO._____

I understand I am responsible for verifying insurance benefits and obtaining necessary prior authorizations and referrals. I also understand that I am responsible for all fees, regardless of my insurance coverage. I have read the above statements and understand them.

I FURTHER UNDERSTAND THAT I MAY REVOKE THIS AUTHORIZATION AT ANY TIME SHOULD I DESIRE BY NOTIFYING THE OFFICE IN WRITING

_____ _____

Date Signature of Patient or
Legal Representative

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TREATMENT AGREEMENT

Welcome to our group private practice. This document contains important information about our professional services and business policies. Please read it carefully and we can discuss any questions you may have in our next meeting.

MEDICAL and PSYCHOLOGICAL SERVICES

As a practice we offer a variety of comprehensive services. There are members of our group who specialize in individual, couples and family therapy. Each therapist's training and treatment approaches may differ, offering a spectrum of treatment modalities. It is our practice to consult regularly with colleagues within our group practice regarding clinical matters, in order to enhance the clinical services we provide. We may also consult with primary care physicians and psychiatric professionals with your permission.

Psychotherapy has both benefits and risks. Risks include sometimes experiencing uncomfortable feelings or recalling unpleasant aspects of your history. However, psychotherapy has been shown to have benefits for people who invest in the process with commitment and realistic expectations. It often leads to significant reduction in feelings of distress, better relationships, and resolution of problems. However, we cannot guarantee any particular resolution to problems or a particular response to treatment.

Therapy involves a commitment of time, money, and energy, so it is important to be thoughtful in selecting a therapist. If you have any questions about any procedures in therapy, it is important *to* discuss them as they arise. If your doubts persist, an appropriate consultation with another mental health professional may be beneficial.

SESSIONS

The first three sessions are considered evaluation sessions. During this time, we will clarify your reasons for seeking treatment, gather pertinent information and history, and determine the best course of treatment to help you meet your objectives.

EMERGENCY OR GENERAL CONTACT

During the weekdays Monday through Friday each therapist will check their voicemail messages. When a therapist is out of the office, he/she will call in to get messages and will return your call as soon as possible.

We do not provide emergency services in our outpatient practice. If you call after hours and it is not an emergency, please leave a message on the voicemail and your therapist will return your call the next business day. If you are experiencing severe distress and cannot wait until the next business day, please call 9-1-1 and go to your nearest emergency room.

PROFESSIONAL FEES

As independent practitioners, each professional in the practice sets his/her own fees based on experience and expertise. Once an appointment hour is scheduled, you will be expected to pay for it unless you provide advance notice of cancellation. Please consult your therapist directly about his/her policy. If you are unable to attend due to circumstances which were beyond your control, we will need to discuss it. Fees will also be assessed for phone consultations, school evaluations/meetings and appearing in court. If you require a service from your therapist or doctor outside of psychotherapy, please discuss fees ahead of time.

BILLING AND PAYMENTS

It is routine procedure to keep a credit or debit card on file for your co-payments. Please discuss specific arrangements with your therapist. You will be expected to pay for each session at the time it is held, unless it is agreed otherwise or you have insurance coverage, which requires another arrangement. In circumstances of unusual financial hardship, it may be possible to negotiate a fee adjustment or a payment plan with your therapist. All balances over 60 days will be charged interest of 1-1/2% per month. There will be a $25.00 charge for returned checks. In the event of any concerns or questions about your bill, the therapist will do whatever he/she can do to address them. In the event that difficulties surface in paying your outstanding balance, it is important to discuss the possibility of implementing a payment plan with your clinician. If your account is more then 120 days in arrears and suitable arrangements for payment have not been agreed to, you need to be aware that the option of using legal means to secure payment, including collection agencies or small claims, may be initiated. If we are forced to pursue collection, you will be responsible for all costs of collection, including reasonable attorney's fees.

INSURANCE REIMBURSEMENT

In order to set realistic goals and priorities together, it is important to evaluate what resources are available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. However, insurance plans vary widely in what they will and will not cover.

It is very important that you determine exactly what mental health services your insurance policy covers. Read your insurance coverage booklet carefully. If you have questions, make sure you contact your plan and inquire. Our billing office or your therapist will try to assist you in deciphering the information you receive from your carrier.

Managed Health Care plans, such as HMO's, often require prior authorization before they will reimburse mental health services. These plans typically cover medically necessary, short-term treatment designed to alleviate acute and severe problems that interfere with one's every-day functioning. In such plans it is necessary to seek approval for additional sessions if those authorized are not sufficient. Although much can be accomplished in short-term therapy, some clients feel that more services are necessary after insurance benefits expire.

You should also be aware that all insurance agreements require you to authorize the therapist to provide clinical information such as diagnosis, clinical treatment plans, or a copy of the entire record. Once in the hands of the insurance companies, we have no control over what they do with the information. If you request it, the submitted report can be shared with you.

Once information about insurance coverage options are clear, it is important to discuss what we can expect to accomplish 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 option to pay for services yourself and not involve your health insurer at all.

CONFIDENTIALITY

A. 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 Portsmouth and Exeter Mental Health professionals are bound to keep all of this information strictly confidential and not release it to any party without your written permission. However, there are certain exceptions to this rule of which you should be aware.

1. The following are some situations, in which a therapist is legally bound to act, even if doing so would breach therapeutic confidentiality.

   First, if a clinician believes that a child under the age of 18 has suffered, is suffering or is in danger of suffering serious physical or emotional abuse, or has been or is being sexually abused, a report must be made to the proper government authority. The same holds true for the elderly or disabled persons who are suffering or have died due to abuse or neglect.

   Secondly, if a professional believes that you are threatening immediate harm to yourself, through a plan of action or inaction, he/she is required to contact a family member or other person who can help protect you, or have you evaluated for hospital admission.

   Finally, if you were to threaten physical violence against another person, there exists the obligation to take some action to protect that person by notifying him/her and the police, and seek to have you hospitalized to prevent harm from coming to them and to you.

   It is our practice, whenever possible, to discuss this with the patient before taking any action.

2. In legal proceedings, the courts usually respect your rights to confidentiality in the treatment relationship, and we are ethically bound to protect that right when testifying in legal or administrative procedures, even when a lawyer issues a subpoena. However, there are circumstances when a judge may over-rule the privilege. For example, confidentiality privileges are waived in a contested custody procedure in a divorce.

3. As previously mentioned, it is our practice to consult within the practice regarding clinical matters. Full confidentiality, therefore will be maintained within our group of clinicians. However, the information shared is only that necessary for the consultation or to insure effective clinical intervention. If you know someone within the practice in a nonprofessional capacity, please inform your therapist right away. Your treatment will not be discussed/consulted with that person or in the presence of that person.

B. MINORS

1. In cases of therapy with minors, parents or legal guardians have rights to information regarding treatment. However, in order for therapy to be effective the child must have assurance of confidentiality. Because of this, it is policy to ask parents to waive their rights to confidentiality information. Information will be shared only with the child's permission, except in the situations where the child's welfare is being compromised by maintaining the confidentiality.

2. When the parents of a minor are divorced or separated, it is expected that both parties be privy to the therapeutic process. We ask that the parent initiating therapy take responsibility of informing the child's other parent that such services are being sought.

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 other wise specified, information that is shared by a member of the unit within the context of that therapy cannot be concealed from other members of the unit. Such secrets can disrupt the trust necessary for effective treatment.

D. OFFICE POLICIES

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

This becomes especially sensitive when relatives call the office requesting even simple information, such as an appointment time for their husband/wife or partner. Even under these simplest of situations, office personnel cannot acknowledge that they know the person, nor can they disclose any information about her/him. If you would like us to have contact with a family member, a release will need to be signed. All requests for records must be accompanied by a signed release of information. It is our office policy to keep records for 7 years from the date the record becomes inactive.

IN CLOSING

It is important that you understand and are comfortable with the issues outlined above. Please feel free to address any questions or concerns you might have with your therapist.

PLEASE SIGN

I HAVE READ, UNDERSTOOD AND RECEIVED A COPY OF THE ABOVE INFORMATION

_____ _____

(Patient) Date

_____ _____

(Therapist) Date

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AUTHORIZATION TO RELEASE/EXCHANGE INFORMATION

I, _____

(Last name, First, Ml, or Maiden name)

of _____

(Address)

DOB _____

hereby authorize and request

_____

(Doctor/Therapist @ PEMHA)

to release to/obtain from _____

(Name, address, & phone # of individual or agency)

_____

the following information _____

covering treatment service dates of _____

in the following manner (please specify): oral written fax (cover sheet required)

including information about HIV/AIDS: _____

(initial)

including information about drug and alcohol use: _____

(initial)

(Please note you are not requires to consent to the release of HIV or drug and alcohol information)

for the following purpose: _____

_____

The protection of the confidentiality of information contained herein is required under Chapter 329 and 330 of the laws of the State of New Hampshire. By signing this release, I acknowledge my permission to release/exchange only the specified information to the individual/agency I have named. This release will expire one year from the date signed unless otherwise specified, or unless revoked in writing prior.

_____ _____

Signature (please specify): parent guardian Date

_____ _____

Witness Date

_____