PATIENT INFORMATION FORM

Name: _____
(Last) **(First)** **(Middle)**

Phone: (H) **(W)** **(Cell):**

Email:

Address:

City:

State: **ZIP:**

Patient's Date of Birth: **Subscriber's Employer:**

Patient's SSN: **Subscriber's SSN:**

Address: **Subscriber's DOB:**

Patient's Occupation: **Relationship to Patient:**

Legal Status: (circle one): Single Married Separated Divorced

Names and ages of children:

Emergency Contact: **Relationship to Patient:**

Person to Receive Bill:

Address (If different from above): **Phone:**

Primary Care Physician: **Phone:**

HEALTH INSURANCE:

State: **Name of Insurance:** **Insurance Address:**

Subscriber ID#: **Group #:** **Subscriber Name:**

Authorization Number: **Number of visits:**

No Insurance (Circle if applicable)

I hereby authorize my insurance benefits to be paid directly to Ava Galante for the medical services rendered. I also authorize her to release any information necessary to process this claim.

Signed: **Date:**

THERAPIST - CLIENT RESPONSIBILITIES:

I am committed to using my professional expertise helping you with whatever problems you bring to counseling or come up during sessions.

We will together to establish your counseling/therapy goals and will clarify these from time to time.

Please read the following carefully and discuss with me any questions you have before signing.

APPOINTMENTS:

Your appointment time is being reserved for you and is scheduled according to your counseling/therapy needs and appointment availability. Standard appointments are approximately 45-50 minutes long. Half sessions are approximately 25 minutes long.

TELEPHONE CALLS/AVAILABILITY:

When I am not in my office, I am available by telephone. My office telephone number is: (781) 572-0065. If I do not answer myself, leave a message on my confidential voicemail. I return calls as soon as possible. If you are experiencing a mental health emergency when you call and do not reach me immediately, go to the nearest Hospital Emergency Room.

On very rare occasions, I may need to take a call during your session. This is only when I am expecting a call from a physician's office or I have a patient who is in crisis. If you wish to have uninterrupted psychotherapy sessions, please let me know and I will not answer any calls.

CANCELLATIONS:

You will be charged $50.00 for a session if you fail to cancel within 24 hours of an appointment unless it is due to an unavoidable emergency. These fail-to-cancel visits are not billable to your insurance. (See "Cancellation Policy" enclosed.)

FEES AND INSURANCE:

My fee is $150.00 for an initial evaluation and $135.00 per session. All fees and co-payments are payable at the beginning of each session, cash or check (payable to me.) Arrangements can be made for payment of fee. My fee for collateral visits or consultations (e.g. court, school, medical team) will be discussed prior to providing these services. If you choose to pay privately instead of using your insurance, the fee is $135 per session. I will work with you to make a payment plan for outstanding balances.

Some insurance requires pre-authorization. Some do not. Some require you to obtain an authorization number, while others require me to fax a request for authorization.

Every effort will be made to use your insurance. Although knowledge of your insurance coverage is your responsibility, I will do what I can to help you determine the specific coverage your policy allows for outpatient Mental Health. In the event your insurance does not cover all or part of the visit, or benefits have been used for this calendar year, you will be responsible for all or part of the visit(s), including deductibles and co-payments as allowed by your insurance.

I will submit claims for all and any other insurance for which I am a network provider.

On January 1, 2001, the Massachusetts Health Parity Law went into effect for Massachusetts residents only. "Parity" refers to Mental Health being guaranteed coverage on a "par" or to the same degree as physical illness. What this may mean to you: If the Parity Law applies to your insurance and to your Mental Health condition, the number of sessions you are allowed in a calendar year is unlimited based on medical necessity. If you have any questions, please call your insurance company to determine if or when the Parity Law will apply to your policy.

OFFICE COVERAGE:

If I am ill or have a personal emergency, I will call to cancel your appointment. If I am unable to call, my colleague will contact you about cancelling the appointment.

Please indicate whether you would like to be called: Yes No

Please Initial: _____

During vacations, my office is covered by one of my colleagues. The name of this therapist will be on my office message.

STATEMENT REGARDING CONFIDENTIALITY

All information shared in this office is confidential unless a specific release of information is signed by you. Some legal exceptions include the following:

- **I believe that you may be a danger to yourself or another person.**
- **Suspicion of abuse or neglect of a child or elderly person.**
- **You are a minor and you share that you are currently or have been physically or sexually abused, or I determine that you are at significant risk.**
- **Your insurance company requests information relative to payment of your claim or another process is required to collect unpaid fees.**
- **I receive a signed order by a judge to testify in court, or to provide records.**
- **Requests from Worker's Compensation plans.**

In the above instances, I will take appropriate action to ensure your safety. Otherwise, I may not reveal any information about you without your written permission. When insurance companies require me to submit clinical information about you to authorize additional sessions, I will try to complete insurance treatment forms together with you so you will know exactly what is being written/said about you. I have no control over the confidentiality of any information once it is disclosed outside this office. If you have any questions about who has access to your information, please contact others to whom you have authorized information to be released

CANCELLATION POLICY

When you schedule an appointment, you are "purchasing" that time. It is yours unless you cancel it 24 hours before your appointment time. As stated previously, the charge for a scheduled appointment not canceled before the 24 hour period is $50.00 unless it is an emergency. You are financially responsible for all sessions. If you have to cancel, I will make every effort to reschedule as soon as possible.

"Emergencies" are considered events beyond your control such as snowstorms, car accidents, funerals, hospitalizations or major illnesses.

Charges for late cancellations or missed appointments are not billable to your insurance company.

If you cancel 2 consecutive appointments, before rescheduling, we will need to discuss your treatment goals and whether you are able to commit yourself to counseling at this time.

If at some point you decide not to continue in counseling with me, please call my office and leave a message, especially if you have appointments scheduled.

It is my intention to provide all of you with the greatest possible selection of appointment times. If you have ever waited for a "cancellation appointment," you can appreciate someone who cancels in sufficient time for you to take that appointment.

During the time we have to work together, you are my priority. I am always happy to hear from you and will always try to accommodate you within the guidelines of this policy.

Signed: **Date:**

RELEASE/REQUEST OF INFORMATION

Client's Name:

I hereby authorize:

Ava Galante, LICSW
10 Cedar St, Suite 36
Woburn, MA 01801
Ph: 1-781-572-0065
Fax: 1-844-364-1720

to release to, or request from:

_____

_____

_____

_____

(name and address)

The following information from my record:

_____

This information is needed for the purpose of:

_____

_____

I understand that this therapist abides by Federal Confidentiality Regulations (42 CFR., Part 2) published July 1, 1975, which protect the confidentiality of my records and that information contained in my record cannot be disclosed without consent unless otherwise provided for in the regulations.

I understand that this directive is subject to revocation at any time upon written request. Otherwise this consent will expire upon one year from date signed.

I herewith release and hold harmless Ava Galante from any liability for the release of any information provided in accordance with this directive.

Signed: **Date:** _____