The Northampton Center For Couples Therapy

ONLINE THERAPY INTAKE FORM - NEW PATIENT

Patient #1

Name | Home Phone

Street Address | Cell Phone

Mailing Address | Work Phone

City | Email

State | Zip Code | Date of Birth

Gender M or F | Marital Status: S M D W

May I call you at any of the above numbers? Y or N | May I leave a message at this email address? Y or N

Primary Care Physician (PCP) | PCP Office Phone

PCP Address

Are you seeing another therapist for mental health services? Y or N

Patient #2

Name | Home Phone

Street Address | Cell Phone

Mailing Address | Work Phone

City | Email

State | Zip Code | Date of Birth

Gender M or F | Marital Status: S M D W

May I call you at any of the above numbers? Y or N | May I leave a message at this email address? Y or N

Primary Care Physician (PCP) | PCP Office Phone

PCP Address

Are you seeing another therapist for mental health services? Y or N

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

Comments:

The Northampton Center For Couples Therapy

Online Therapy – New Patient

PATIENT CONSENT AND AUTHORIZATION

Consent to Treatment: _____ Initials

I hereby consent to receive mental health treatment from Northampton Center for Couples Therapy (hereafter referred to as NCCT). I understand that my consent is voluntary. I also understand that I do not have to accept any treatment option NCCT 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 reductions in feelings of distress.

I acknowledge that online therapy is therapy done remotely via a computer, Internet and webcam. It is not face-to-face therapy. I understand I must participate in a face-to-face assessment as the initial step of this process to determine if online therapy is an appropriate option for my care. I attest that I am a Massachusetts resident and will only conduct online therapy sessions while in the boundaries of the state of Massachusetts. I also acknowledge that in order to participate in online couples therapy, both members of the couple must be present in the same room during the remote online session.

Online therapy is more easily accessible due to geographic or time constraints, but also has limitations because of the remote aspect and technology used during the session. I understand that video and sound quality is dependent on many factors like hardware, software, Internet connection/speed, external noise, lighting, etc. These factors may cause my online session to be interrupted or terminated. In the event of a technological glitch or interruption, my therapist will attempt to contact me at the alternate number (preferably a landline) I provide, so that we can attempt to resume the online session or reschedule for another date.

Release of Medical Records: _____ Initials

I understand in order for any therapy information or medical records to be released, **both** members of the couple must provide written authorization. If some individual sessions may help the process of online couples therapy, what I say in those individual sessions will be considered to be a part of the medical record.
I also understand that information discussed in online couples therapy is for therapeutic purposes and is not intended for use in any legal proceedings involving the couple. I agree not to subpoena my therapist to testify for or against either party or to provide records in a court action.

Online Therapy Sessions: _____ Initials

I understand that by choosing online therapy, I am agreeing to the following:

- My online therapy session must be conducted using the platform chosen by NCCT. Any other means of communication will not be allowed for my online sessions unless initiated by my therapist.
- Technology limitations can cause interruptions in my online sessions. These limitations can include but are not limited to; hardware problems, software issues, Internet connection/speed, power outage, etc.
- Confidentiality and privacy are dependent on a quiet, uninterrupted environment. There should be no other unidentified individuals in the room during my remote online session. If there are others in the room, they must be disclosed and all parties involved in my session must be made aware and consent to their presence.
- During my online therapy session, there can be possible misunderstandings when visual cues are absent in communications.
- Seating and lighting should be tailored to allow maximum comfort to all involved in the session.
- Clarity and visibility of the person(s) at the other end of the video services should be maximized.
- Computers/cameras used during my online therapy session should be on a secure, stable platform to avoid any movement interruption during the video session.
- I must provide an alternate phone number to my therapist in the event of an interruption of my session.
- My therapist may request the contact information of a family member or community member who could be called upon for support in the case of an emergency.
- My therapist may also request to know if I have any limitations in terms of travel to local emergency services.
- The computer I use for my online therapy sessions has up to date antivirus protection and a personal firewall is enabled.
- My online therapy sessions will be not be recorded unless I give my consent and authorization.

I also understand that there are circumstances in which online therapy may not be the best treatment option for me. Such circumstances may include when there is:

- An undisclosed, ongoing or recent affair.
- Active addiction (drugs, alcohol, etc.).
- Serious violence in my relationship, threats of serious violence or fear of serious violence on the part of one or both partners.
- An untreated, diagnosable mental illness (bipolar, psychotic disorders and major clinical depression). This does not include past and successfully treated mental health conditions that are currently stable and/or in remission.
- Suicidal or homicidal thoughts, or a history of serious harm inflicted on another person.
- Lack of commitment to the therapy process.

I further understand that NCCT 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 NCCT to date (regardless of duration of treatment) are nonrefundable. I understand that in such circumstances NCCT 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.

Confidentiality: _____ Initials

I understand that our communications are private and protected by law. Because of laws protecting confidentiality, in 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 NCCT 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. NCCT has a contract with a billing service. As required by HIPAA, NCCT 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. Generally, if I am involved in legal proceedings, my therapist cannot provide any information about our work without my permission. There are exceptions and, if I anticipate being involved in litigation, I should consult my attorney to determine whether a court could order my therapist to disclose information.

5. 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.

6. 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.

7. 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.

8. 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/her 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 NCCT 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 all fees for my online therapy services provided by NCCT. I understand that my insurance will not cover online therapy sessions. Payment must be made before my session can begin.

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:_____

The Northampton Center For Couples Therapy

CANCELLATION AND ATTENDANCE POLICY

Online Cancellation Policy: _____ Initials

If I am unable to keep an appointment, I agree to notify NCCT 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.

Online Attendance Policy: _____ Initials

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

If I miss more than one appointment within a month for any reason, I will be charged a $150 fee (per week) so that my slot can be held.

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

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:_____

The Northampton Center For Couples Therapy

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 investigating 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 agree to 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 413.586.2300 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 Security Officer at 40 Main Street, Suite 206, Florence, MA 01062. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. Our Security Officer 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 me. 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 PHI to perform their jobs properly. To protect your privacy they have agreed in a signed contract to safeguard your information.

The effective date of this notice is April 14, 2003.

The Northampton Center For Couples Therapy

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 NCCT:

SIGNATURE OF PATIENT OR GUARDIAN **DATE**

GUARDIAN'S NAME (*Please print)* **RELATIONSHIP TO PATIENT**

The Northampton Center For Couples Therapy

CREDIT CARD PROCESSING FORM

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

Patient Name _____

Cardholder (as appears on card)_____

Address (statement address) _____

_____

__VISA __ Mastercard __ American Express __ Discover

Credit Card #_____

Expiration Date:_____**CVV # (3 digits on back of card):** _____

Cardholder Signature _____

☐ (please check if applicable) I am also authorizing NCCT and it's Billing Agency to use the above listed credit card for my spouse/partner 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 NCCT to apply balances from my spouse/partner's account although my spouse/partner's name is not on the credit card being used at this time.

Print Spouse/Partner's Name _____

Signature of Spouse/Partner _____

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

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

Effective 10/1/2012 Signature of NCCT Credit Card Processing Form is required of all NCCT clients.