TAK Center for Mental Health

HIPAA & Consent

Today's date: / / **Primary Care Physician:**

Patient's last name:	**First:**	**Middle Initial:**	**Marital status (circle one):** Single / Mar / Div / Sep / Wid
Former name (if applicable):	**Birth date:** / /	**Age:**	**Sex:** ❑ M ❑ F
Street address:		**Home phone no.:** ( )	**Cell phone no.:** ( )
P.O. box:	**City:**	**State:**	**ZIP Code:**

Race (check all that apply): ❑ American Indian or Alaska Native ❑ Asian ❑ Native Hawaiian or Other Pacific Islander ❑ Black or African American ❑ White ❑ Hispanic ❑ Other Race		**Ethnicity (check one):** ❑ Hispanic or Latino ❑ Not Hispanic or Latino
Social Security No.: _______ - ______ - ___________	**E-mail Address:**	**Preferred Pharmacy/Location:**

By signing below, I acknowledge the following:

- I give TCMH (TAK Center for Mental Health) consent to access my prescription history, including all past prescribed medication, in order to verify future prescription refills.
- I give TCMH consent to bill my insurance company for any fees related to services provided by their staff, perform reasonable and necessary medical examinations, testing and treatment at the discretion of its healthcare professionals based on their clinical judgment of my condition.
- I give TCMH consent to bill me directly for any charges denied by my insurance company, and for any charges incurred in the event of lack of insurance coverage at the time of care.
- I understand that TCMH is not responsible for any bills incurred by me for testing, imaging, or services provided by outside facilities, including those services ordered by their staff.
- I give TCMH consent to call, text, and/or email an appointment reminder to the phone number listed above. I understand that there may be a voicemail left for me at this phone number.
- I acknowledge that I have been given access to TCMH's Notice of Privacy Practices.
- I authorize TCMH to discuss my health information with the following person(s):

Name	Telephone #	Relation
Name	Telephone #	Relation

❑ Self Only: *If checked, TCMH will not release your information to anyone except as outlined in our Notice of Privacy Practices. Please initial* __________________

I release TAK Center for Mental Health (TCMH) from all responsibility and liability that may arise from this authorization. I may withdraw this authorization at any time by giving written notification to TCMH, provided that I do so in writing and to the extent that we have already disclosed the information in reliance on this authorization.

Patient Signature (or *Guardian if patient is under the age of 18*) Date

Witness Signature Date

1069 Central Street, Leominster MA 01453 T: 978.728.4957 F: 978.798.1366

AUTHORIZATION/REQUEST FOR RELEASE of BEHAVORIAL HEALTH RECORD

(Also known as Protected Health Information)

Date: / /

Patient Name ____ Date of Birth ______________

Therapist Provider Information

Deborah Parsons, LMHC
1069 Central Street, Leominster, MA 01453

Behavioral Health Provider Information

Dr. Ramteen Rezai
1069 Central Street, Leominster, MA 01453

Meagan Dembitzky, N.P.
1069 Central Street, Leominster, MA 01453

I, (or on behalf of) ____ give permission to the providers listed above to exchange information about my medical and behavioral health.

In addition:

I authorize the exchange of information about any substance or alcohol abuse in my medical records.

[ ] Yes [ ] No

I authorize the exchange of information about any HIV blood tests results or HIV- or AIDS- related care in my medical records.

[ ] Yes [ ] No

1. I understand that, unless withdrawn, this authorization will expire 1 year from the date of signature. A photocopy of this form will be considered as valid as the original.
2. I understand that I may revoke this authorization at any time by notifying the TAK Center for Mental Health at the address indicated above, in writing, and this authorization will cease to be effective on the date notified unless the information has already been released.
3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations. However, other state or federal law may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information and mental health information.
4. I hereby release all parties stated herewith from any liability resulting from the release of this information.

By signing below, I acknowledge that I have read and understand this Authorization.

____ ________________
Signature of Patient Date

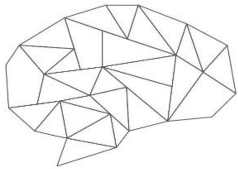
____ _________________
Signature of Legally Authorized Representative Relationship and Date

____ _________________
Printed Name of Authorized Representative Date

Refusal to Release Information

I do not consent to release the information as described above. However, I understand that if I do not allow my providers to exchange information about me, their ability to fully coordinate my care may be limited. I understand that in an emergency situation my providers may exchange information about me to the extent necessary.

Signature of patient/guardian _____________________________________ Date _________________



TAK
Center for Mental Health

1069 Central Street, Leominster MA 01453 T: 978.728.4957 F: 978.798.1366

Confidentiality/Informed Consent for Psychotherapy

The session content and all relevant materials to the client's treatment will be held confidential unless the client requests in writing to have all or portions of such content released to specifically named person(s).

Limitations of this confidentiality are indicated below:

1. If a client threatens or attempts to commit suicide or otherwise conducts him/herself in a manner in which there is a substantial risk of incurring serious bodily harm.

2. If a client threatens grave bodily harm or death to another person.

3. If the therapist has a reasonable suspicion that a client or other named person is the perpetrator, or observer of, or victim of physical, emotional, or sexual abuse of children under the age of 18 years.

4. Suspicions as stated above in the case of an elderly or disabled person who may be subjected to these abuses.

5. In a legal proceeding, the release of client information may be mandated by court order.

I have read and understand these limitations to confidentiality and give my consent to treatment in psychotherapy.

____	______________
Signature of Patient	Date
____	__________________
Signature of Legally Authorized Representative	Relationship to Patient
____	______________
Printed Name of Authorized Representative	Date

1069 Central Street, Leominster MA 01453 T: 978.728.4957 F: 978.798.1366

THERAPY TERMS AND TREATMENT

In order to maximize the benefits of therapy, it is very important that all scheduled appointments be attended. The consistency of attending therapy sessions assures that you will obtain maximum treatment benefit and assists you in meeting your goals. Missed or late appointments disrupt therapy schedules, which impacts you, your therapist, and other patients. By signing this form, you are indicating that you understand our attendance policy and consequences of not keeping your appointments.

We anticipate that you will adhere to the following:

1. In understand that any appointment missed for any reason is considered an absence. Two times tardy for therapy equals an absence. ____ (initial)
2. I agree to call to cancel my appointments at least 24 hours in advance. If I do not call to cancel and do not attend therapy, this will be considered a "no-show". If appointments are not cancelled at least 24 hours in advance you will be charged a fee of $100 for the first missed appointment and $150 for the second missed appointment. A third missed appointment will result in immediate termination of therapy. This will also result in the possible termination of care for medication management in our office as well. This fee will be added to your account and is the patient's responsibility, as we cannot charge your insurance company for your missed appointments. This fee is due BEFORE your next scheduled visit- *therapy or medication management*. ____ (initial)
3. I understand that if I arrive fifteen minutes late without prior notification, my appointment will be considered a no-show and I will be charged accordingly. Sessions that begin late will still end at your scheduled appointment time. ____ (initial)
4. I understand that missing three scheduled therapy appointments, for any reason, in six-month period is grounds for discharge form therapy. If I must cancel an appointment due to illness or emergency, I will contact the office as soon as possible. Family emergencies will be taken into consideration. ____ (initial)
5. I agree to notify the therapist at least two weeks in advance of vacations or extended leave of absence from therapy. Needing to miss two consecutive appointments (biweekly patients) or three consecutive appointments (weekly patients) will result in forfeiting your therapy "spot". ____ (initial)

Following these guidelines will greatly facilitate quality treatment. Thank you for your cooperation.

____ ______________
Signature of Patient Date

____ ________________
Signature of Legally Authorized Representative Relationship to Patient

____ ______________
Printed Name of Authorized Representative Date