DX: _____ THERAPIST NAME: MARSHA L. GETTER, LICSW

If this is NEW INS. INFO for an existing patient, please list the effective date of the new policy here: _____

PATIENT & INSURANCE INFORMATION

PLEASE PRINT

Patient's Name: _____ DOB: _____
(Last) (First)

Patient's Address:
Street/City/State/Zip:_____

(W) (_____)_____

Patient's SS#: _____ Phone #: (H) (_____)_____

Email: _____ (C) (_____)_____

Patient's Marital Status: (please circle) Single Married Other

Primary Insurance Company:_____

Insurance ID #: _____ Group #: _____

Subscriber's Name: _____ SS#: _____ DOB: _____

Subscriber's Employer: _____

Patient's Relationship to Subscriber: (please circle) Self Spouse Child Other

Secondary Insurance Company:_____

Insurance ID #: _____ Group #: _____

Subscriber's Name: _____ SS#: _____ DOB: _____

Subscriber's Employer: _____

Patient's Relationship to Subscriber: (please circle) Self Spouse Child Other

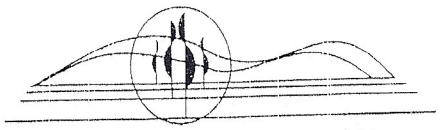
(Primary Insurance Co.)	(Secondary Insurance Co.)
Insurance MENTAL HEALTH CLAIMS Address & Phone #:	
Street/P.O. Box #	Street/P.O. Box #
City State Zip	City State Zip
Phone #:	Phone #:

Person responsible for any balances not covered by insurance:

_____

INSURANCE AUTHORIZATION & ASSIGNMENT: I hereby authorize the release of medical information to my insurance carrier & assign payment to the provider for medical services rendered to myself or my dependents. I understand I am responsible for any amount not covered by insurance.

_____ _____
DATE SIGNATURE



Neponset Valley Counseling Center

Name (Print) _____

Primary Physician

Primary Physician: _____

Address: _____

_____

Telephone: _____

May we contact your primary concerning your treatment? ☐ YES ☐ NO

Signature (Patient or Parent/Guardian of Minor) _____ Date _____

Please list any and all medications, vitamins, herbal supplements you take on a regular basis or within the last 10 days?

MEDICATION	DOSAGE	HOW YOU TAKE IT

NEPONSET VALLEY COUNSELING CENTER

OFFICE POLICIES AND PROCEDURES

Welcome to Neponset Valley Counseling Center. In order to best serve you, I would like to clarify some points that relate to the delivery of our services. Please keep one copy of this for your records and give a signed copy to your clinician. Please feel free to ask your clinician any questions that you may have regarding any of this information.

FEES: It is required that you make full payment at the time of your visit or provide us with the necessary documentation in order for us to access your insurance benefits. **Please note that you, not your insurance company, are ultimately responsible for all fees. Additionally, if you neglect to notify our office of any changes to your insurance and your visits are denied, you will be responsible for the full fee.** See the chart at the bottom of the page for the cost of our clinical and non-clinical services**.** For your convenience, NVCC accepts personal checks, all major credit cards, and cash. A 21% interest charge may be levied on all unpaid accounts. If it becomes necessary to turn your account over to collections, you will then be responsible for all collection fee as well as all applicable NVCC charges.

MISSED APPOINTMENTS: At least a 24-hour notice is required if you need to cancel your scheduled appointment. For your convenience, our answering system can be accessed 24/7 by calling my direct line at (508) 930-6335. **You will be charged a full fee for late cancellations or missed appointments.** Please note that insurance companies do not pay for late cancellations or missed appointments and you will be responsible for payment.

EMERGENCIES: Although NVCC does provide a 24-hour system and I make every effort to promptly return all phone calls, **NVCC is not able to provide emergency services.** If you are having a psychiatric emergency or crisis, I recommend that you immediately contact your local hospital emergency room or police.

CONFIDENTIALITY: NVCC carefully protects your confidentiality and your anonymity. You will receive a "***Notice if our Privacy Practices"*** in accordance with H.I.P.A.A.

Clinical Service Fees (sliding scale available for self-pay patients)

Initial Evaluation	$160/hour
Individual Therapy	$150/hour
Family Therapy	$150/hour

Non-Clinical Service Fees (sliding scale available for self-pay patients)

Documentation Fees (are not covered by insurance)

- Letter: $35
- 1-page report: $110
- Each additional page: $85
- Co-pay not paid at time of appointment: $15
- Returned check or denial of credit card: $35

- Consultation: $250/hour
- Parent Coordination: $250/hour
- Guardian ad Litem: $350/hour
- Mediation of Parenting Plans: $250/hour
- Reunification Therapy: $250/hour

All patients are responsible for any fees incurred if, as a result of your clinical treatment at Neponset Valley Counseling Center, your therapist is asked or required, on your behalf, to give testimony in court to be deposed, and/or to provide any other non-clinical services (services not covered by your insurance carrier.)

Your signature below indicates that you have read and that you have read and fully understand the above information, fee schedule, and conditions regarding payment services, both clinical and non-clinical. I hereby authorize the provider of service to furnish information to insurance carriers concerning my condition and treatment. I hereby assign to the provider all payments for medical/mental health services rendered to my dependents and/or myself. I UNDERSTAND I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.

_____

Signature (Parent or Guardian for a minor) **Date**

_____

Print Name

NEPONSET VALLEY COUNSELING CENTER
Marsha L. Getter, LICSW
342 Del Pond Drive Canton, MA 02021
Phone (508) 930-6335 Fax (781) 828-1927

Unencrypted Emails and Text Messages to Patients

We offer helpful administrative information by regular text messaging and email-like appointment reminders and communications. There is some level of risk that information in a regular text message or email could be read by someone besides you. Please let us know if you would like us to communicate with you by text message or email.

☐ **Yes – Please communicate with me by email. My email address is (please write legibly):**

_____

I will let you know right away if my email address changes.

☐ **No – Please do not communicate with me by regular (unencrypted) email**

☐ **Yes – Please communicate with me by text message. My cell phone number is (please write legibly):**

_____

I will let you know right away if my cell phone number changes.

☐ **No – Please do not communicate with me by regular (unencrypted) text message**

_____

Patient Signature **Date**

Marsha L. Getter, LICSW
Neponset Valley Counseling Center
342 Del Pond Drive Canton, MA 02021
Phone (508) 930-6335 Fax (781) 828-1927

Authorization: Mental Health Treatment

I, _____[Insert Name of Patient/Client], whose Date of Birth is _____,

authorize Marsha L. Getter, LICSW, to disclose to and/or obtain from:

_____ the following information:
[Insert Name of Person or Title of Person or Organization]

Description of Information to be Disclosed
(Patient/Client should initial each item to be disclosed)

_____ Assessment
_____ Diagnosis
_____ Psychosocial Evaluation
_____ Psychological Evaluation
_____ Psychiatric Evaluation
_____ Treatment Plan or Summary
_____ Current Treatment Update
_____ Medication Management Information
_____ Presence/Participation in Treatment
_____Nursing/Medical Information
_____ Educational Information
_____ Discharge/Transfer Summary
_____ Continuing Care Plan
_____ Progress in Treatment
_____ Demographic Information
_____Psychotherapy Notes*
(*Cannot be combined with any other disclosure)
_____Other_____
_____Other_____

Purpose
The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services.

If the purpose is other than as specified above, please specify:
_____
_____

Revocation
I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Marsha L. Getter, LICSW at Neponset Valley Counseling Center. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration

Unless sooner revoked, this authorization expires on the following date: _____ or as otherwise indicated:_____

Conditions
I further understand that Marsha L. Getter will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences:
_____
_____
[Insert an explanation of the consequences, if any, of not signing this authorization, which will depend on the services being provided].

Form of Disclosure
Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Redisclosure
I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections.

I will be given a copy of this authorization for my records.

_____
Signature of Patient/Client Date

_____
Signature of Parent, Guardian or Personal Representative Date

_____Check here if patient/client refuses to sign authorization

_____
Signature of Staff Witness Date

Marsha L. Getter, LICSW

Neponset Valley Counseling Center
342 Del Pond Drive Canton, MA 02021
Phone (508) 930-6335 Fax (781) 828-1927

Notice of Privacy Practices
Receipt and Acknowledgment of Notice

Patient/Client Name:_____
DOB: _____
SSN:_____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of the Neponset Valley Counseling Center's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Marsha Getter for information.

_____
Signature of Patient/Client **Date**

_____
Signature or Parent, Guardian or Personal Representative * **Date**

_____
* If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

☐ **Patient/Client Refuses to Acknowledge Receipt**:

_____
Witness **Date**