INITIAL CLIENT INFORMATION

NAME: (LAST) _____ (FIRST) _____ (INITIAL) ____

PHONE: (H)_____(C)_____(W)_____

ADDRESS: **MAILING ADDRESS (IF DIFFERENT):**

STREET: _____ PO BOX/STREET_____
CITY: _____ CITY: _____
STATE: _____ ZIP: _____ STATE: _____ ZIP: _____

Date of Birth: _____ **Age**: _____ **Email**: _____

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

Occupation: _____

Emergency Contact #1: _____Relationship: _____
Phone: (H)_____(C)_____(W)_____

Emergency Contact #2: _____Relationship: _____
Phone: (H)_____(C)_____(W)_____

Person To Receive Bill (if applicable): _____
Relationship: _____
Phone: H)_____(C)_____(W)_____
Address: _____

Primary Care Physician: _____ Phone: _____
Address: _____

HEALTH INSURANCE:
Name of Insurance: _____ **Member ID**: _____
Phone: _____ Group #: _____
Subscriber: _____ Rel. to Subscriber: _____
Subscriber's Date of Birth:_____
Subscriber's Address: _____

No insurance (Circle if applicable)

I hereby authorize my insurance benefits to be paid directly to Rebecca Boyko, LICSW for psychotherapy services rendered. I also authorize Rebecca Boyko, LICSW to release my information necessary to process this claim.

Signature: _____ Date: _____

INFORMED CONSENT REGARDING LIMITATIONS ON CONFIDENTIALITY

Client Name: _____

I understand that information about my (and/or my child's) treatment and communications with my therapist may not be released without my written authorization. Noted exceptions are as follows:

1. If it is necessary to protect my safety or the safety of others:
   A) If I am clearly a danger to myself, my therapist may take steps to seek involuntary hospitalization. My therapist may also contact members of my family or others if it is necessary to protect my safety.
   B) If I threaten to kill or seriously hurt someone and my therapist believes I may carry out my threat, or if I have a known history of physical violence and my therapist believes I will attempt to kill or seriously hurt someone, my therapist may:
      - Tell any reasonably identified victim; and/or
      - Notify the police; and/or
      - Arrange for me to be hospitalized.
   C) If I report prenatal exposure to controlled substances that are potentially harmful, my therapist is required to report this information to legal authorities.
2. If it is necessary for my therapist to place or keep me in a hospital for psychiatric care to protect my safety.
3. If a judge thinks my therapist has important evidence about my ability to provide suitable care or custody in a child custody or adoption case.
4. In court proceedings involving the care and protection of children or to dispense with the need for parental consent for adoption.
5. If my therapist believes a child, a disabled person, or an elderly person in my care is suffering injury as a result of abuse or neglect.
6. To provide information regarding my diagnosis, prognosis, and course of treatment to an insurance company or government agency paying for these services.
7. In a legal proceeding where I introduce my mental or emotional condition or in a legal proceeding where my mental and emotional condition is introduced in the event of my death.
8. If I bring an action against my therapist and disclosure is necessary or relevant to a defense.
9. If necessary to use a collection agency or other process to collect amounts I owe for services.
10. If a court issues a "bishop" order giving access to my records to defense counsel in a sexual assault or other criminal case.

I also authorize my therapist to discuss my treatment with other mental health professionals as necessary including but not limited to vacation/illness coverage, record review and consultation.

I have received a copy of the Client Mental Health Bill of Rights and Complaint Process.

I have read the above and have had the opportunity to discuss this informed consent statement with my therapist. I understand its content and consent to receive treatment based on this understanding.

_____ _____
Client (Guardian/Parent) Date

_____ _____
Therapist Date

CLIENT MENTAL HEALTH BILL of RIGHTS and COMPLAINT PROCESS

The information below explains your rights and the process of complaining if you believe your rights have been violated.

***Every client shall have the right*:**

1. To be treated with respect in a manner that protects your privacy and dignity, regardless of race, national origin, gender, age, sexual orientation, religious or political affiliation;
2. To have confidentiality of all communications and or records to the extent provided by the law;
3. To be informed by your clinician on your diagnosis, prognosis and plan of treatment;
4. To participate in decisions about your care;
5. To have all reasonable requests responded to promptly and adequately within the therapist's capacity and scope of practice;
6. To experience humane care and protection from harm, abuse or neglect.

If you believe that your client rights have been violated, contact the following to file a complaint:

Board of Social Work
239 Causeway Street
Boston, MA 02124
1-617-727-3073

Complaint Unit
Division of Health Care
10 West Street, 5th Floor
Boston, MA 02111
1-800-462-5531

STATEMENT REGARDING PRIVATE HEALTH INFORMATION

Client Name: _____

It is the intent of this office to be in compliance with the Privacy Standards for Private Health Information (PHI) covered under Health Insurance Portability and Accountability Act, also known as HIPPA.

- Right to Request Record Restrictions: I may request restrictions on the use of my protected health information, however, my therapist is not required to agree with the request if the information is related to my diagnosis or to one of the exceptions to confidentiality under the law.
- Right to Inspect and Copy: I have the right to obtain a copy and/or inspect my protected health information unless it is determined that it would adversely affect my wellbeing or if I am a minor. My therapist will discuss this decision with me. My request must be fulfilled by my therapist within 60 days of my written request. There may be a charge for copies.
- Right to Amend: I have the right to request an amendment to but cannot expunge ("erase") information in my record. My therapist may deny this request under certain circumstances. If denied, my request will be kept in the record.
- Right to an Accounting: I have the right to receive an accounting of disclosures of my protected health information. At the time of my request, my therapist will discuss with me the details of the accounting process.
- Right to Receive Confidential Communications by Alternative Means and at Alternative Locations: I have the right to request and receive confidential communications of my protected health information by alternative means and at alternative locations.

I have read and received a copy of the above Privacy Standards for Private Health Information covered under HIPPA.

_____ _____

Client (Guardian/Parent) Date

CLIENT TREATMENT AGREEMENT

Client Name: _____

I, _____, have requested treatment from *Bridge to Healing Psychotherapy LLC with Rebecca Boyko, LICSW* and understand the following conditions:

1) My therapist Rebecca Boyko, LICSW may bill my health insurance carrier on my behalf. Any payments received by my therapist will be credited to my account. I hereby assign my insurance benefits to be paid to Rebecca Boyko, LICSW. I also authorize Rebecca Boyko, LICSW to release pertinent and necessary information required in the course of my treatment and/or my child's treatment to my insurance company for claims processing and authorization/precertification of benefits.
2) If my insurance does not cover the full cost of services, I understand and agree that I am personally responsible for the full amount of services billed.
3) I understand that it is my responsibility to verify that mental health benefits are covered by my insurance for my treatment by Rebecca Boyko, LICSW.
4) Timely payment for the cost of treatment is my responsibility.
5) Copayments, deductible, coinsurance are/or private fee-for-service amounts are due and are payable at the time of visit. If I am unable to pay at the time of the visit, I will discuss alternative payment arrangements with my therapist.
6) If I am paying for sessions privately without insurance, the fees that I am quoted at the start of my therapy may be increased at the end of the calendar year in which I started treatment. If for whatever reason I was in treatment during the ending of a calendar year and did NOT have an increase in my fees, my fees may be increased at any time during the course of the following year. I will be notified at least one month in advance of an increase in fees. I understand that the fee increases will be modest and not excessive.
7) In situations involving divorce/separation, the accompanying parent is responsible for the copayment/fee unless other written arrangements are made.
8) *SINCE MY APPOINTMENT TIME IS RESERVED FOR ME, I AGREE TO CANCEL ALL APPOINTMENTS NO LATER THAN 24 HOURS IN ADVANCE WITH THE EXCEPTION OF EMERGENCY SITUATIONS.*
9) If I no-show to a scheduled session or cancel within less than 24 hours-notice, I am responsible for the full fee of the session which is either the contracted rate with insurance or the private fee. This fee may be charged by the credit card I have on file with my therapist unless other arrangements have been made.
10) Returned check fee is **$25.00** per incident.

I have read this agreement and understand my responsibilities in signing it. If I have any questions, I will address them with my therapist beforehand.

_____ _____

Client (Guardian/Parent) Date

CREDIT CARD AUTHORIZATION FORM

Please complete all fields. You may cancel this authorization at any time by contacting Rebecca Boyko, LICSW. This authorization will remain in effect until cancelled.

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX □ Other _____
Cardholder Name (as shown on card): _____
Card Number: _____
Expiration Date (mm/yy): _____ 3 digit code on back: _____
Cardholder Billing Address: _____

I, _____, authorize *Rebecca Boyko, LICSW at Bridge to Healing Psychotherapy, LLC* to charge my credit card above for no-show/late cancellations per the payment policy outlined in the Client Treatment Agreement. I understand that my information will be saved to file for future transactions on my account.

_____ _____

Client (Guardian/Parent) Date