

The Rested Mind, LLC

Fee Schedule

	NP/MD	Therapist
Initial Evaluation (60 minutes)	\$ 250	\$150
Medication Management Follow-up (20 minutes)	\$ 85	
Medication Management w/therapy (50 minutes)	\$150	
Medication Check-Up (15 minute)	\$ 85	
Individual therapy / no meds (45 minutes)	\$110	
Individual therapy (50minutes)		\$ 95
Telephone Consultation (minimum)	\$ 25	\$ 25
Family/Couples Therapy	\$110	\$110
Late cancellation/ No show	\$100	\$100

Written Documentation (school notes, SSI, SSDI forms, work documentation) – varies dependent on request (\$50 maximum), please inquire

We are currently accepting MassHealth, Blue Cross Blue Shield (all forms), Harvard Pilgrim, Tufts, Cigna, Compsych, Aetna, Teamsters, Neighborhood Health, BMChealthnet, UnitedBehavioral Health and Self-Pay. This means that we will bill your insurance directly and **you will be responsible for your co-pay at the time of your visit. You will not be seen without co-payment.**

For other insurance panels, you will need to call the number on the back of your insurance card to find out your mental health benefits/coverage. Most insurance companies have allowance for out of network coverage available in order to be seen. You may be subject to a deductible or simply have a higher co-pay. It is usually worth your while to check on what your out of network benefits are.

****Appointments cancelled in less than 24 hour notice are billed at \$100 dollars. We reserve the right to terminate you as a patient if there are too many missed appointments.**

Secondary insurance is your responsibility. If you have any questions, please discuss this information with me at any time to determine how it applies to your individual account or insurance policy.

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CONFIDENTIAL CLIENT INTAKE FORM

Patients Name: _____

If minor child, Parent/Guardians' name _____

Pt's Age: _____ **Date of Birth:** _____ **SS#** _____

Gender: Male Female Transgender

Home Address: _____

City: _____ Zip _____

Email Address: _____ **May we email you Yes/ No**

Best Contact Phone number: _____

Telephone Numbers (**Please provide only numbers at which you give me permission to call**)

Home: May leave a detailed message? ___yes ___*no _____

Work: May leave a detailed message? ___yes ___*no _____

Cell: May leave a detailed message? ___yes ___*no _____

Emergency Contact Name _____ **Relationship** _____

Phone _____

SOCIOCULTURAL BACKGROUND:

Racial/Ethnic Background:

White/Caucasian _____ African-American /Black/ African _____

Asian-American Asian or Pacific Islander _____

Hispanic-American/ Latino/Latin American/Hispanic _____

Arab-/Middle Eastern-American _____ Native American/Alaskan Native _____

Multiracial / Bi-racial/ Other _____

How much do you identify with your ethnic heritage?

Not at all A little Somewhat Moderately Strongly

Do you identify yourself in other ways that are meaningful to you (e.g., cultural background, sexual orientation, class status, physical ability)? Please list:

Religious preference?: _____

ACADEMIC/ WORK BACKGROUND:

Place of employment: _____

Position: _____

Highest Educational Degree: _____

Major: _____

Are you a student? Y/ N **If yes, where are you studying:** _____

RELATIONAL/ SUPPORT HISTORY:

Please indicate your current relationship status:

Single _____ In a Committed Relationship _____ Living with Partner _____

Married _____ Separated _____ Divorced _____ Widowed _____

Other: _____

FAMILY BACKGROUND:

Please list the members of your family currently living with you, their genders, their occupations, and their ages (e.g. father, M, Lawyer, 42; sister, F, teacher 29; son, M, student, 12; partner, M, doctor, 35):

Family Member	occupation	age
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PHYSICAL HEALTH:

How is your physical health at present? Poor Satisfactory Good Very good

When was your last physical examination? _____

Please list all Medical problems or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.):

Do you have a disability ? No Yes (if yes, what is your disability?)

Specify: _____

Are you presently taking any prescribed medication? Yes No

Please list all medications, dosages and the reason for which each is prescribed, name of prescribing physician (ie. Paxil 20mgs am / social anxiety / Dr. Joseph):

Please list all allergies: _____

Name of your primary care physician & phone number:

Are you having any problems with your sleep habits? No Yes

Are you having any difficulty with appetite or eating habits? No Yes

Have you had a significant weight change in the last 2 months? No Yes

Do you have any problems or worries about sexual functioning? No Yes

How many times per week do you exercise? _____

MENTAL HEALTH HISTORY:

Have you ever been a victim of: *(if you do not feel comfortable completing this section, simply leave it blank or write prefer to discuss)* Emotional abuse as a child Physical abuse as a child Sexual molestation/abuse as a child. Emotional abuse by a partner/spouse Physical abuse/assault by a partner/spouse Sexual abuse/assault as an adult Other Trauma

Specify: _____

Have you received counseling here or elsewhere before? Yes No

If yes, where: _____ **When:** _____

Duration: _____

What was the focus of previous counseling?

Are you currently seeing a psychiatrist or have you seen a psychiatrist in that past? Yes No

If yes, where: _____ **When:** _____

Please list all psychiatric Inpatient Admission, starting with most recent:

How often are you having suicidal thoughts presently? Sometimes Rarely Never

How often have you had suicidal thoughts in the past? Sometimes Rarely Never

When: _____

How often are you having thoughts of harming others presently? Sometimes Rarely Never

How often have you had thoughts of harming others in the past? Sometimes Rarely Never

When: _____

Have you ever intentionally inflicted any harm upon yourself? Yes No

If yes, When: _____

Have you ever attempted suicide? Yes No **If yes, when and how?**

*****Is there mental illness in your family?** Yes No

Describe: _____

ALCOHOL AND OTHER DRUG USE:

How often do you drink alcohol?

In a typical week, on how many days do you have 4 or more drinks? _____

How often do you use other drugs (marijuana, cocaine, ecstasy, oxycontin, etc)?

Daily 1-2X per week Weekly Monthly Less than monthly Never

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Do you, or does someone else, think that you may need to cut down or stop using other drugs? Yes No Maybe

Last Detox date/admission: _____

Are you currently in methadone or suboxone management ? Yes No

Do you smoke? Yes / No **If yes, how much?** _____ **per day**
When did you start smoking? _____

SIGNATURE:

I verify that the above information is accurate to the best of my knowledge.

Client Name

Client Signature & Date

Parent signature for minor child

The Rested Mind, LLC

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY

If you have any questions about this notice, please contact the Owner of our office at 781-374-4100 , 62 Derby St, Suite 14 Hingham, MA 02043

WHO WILL FOLLOW THIS NOTICE

This notice describes information about privacy practices followed by our employees, staff and other office personnel. The practices described in this notice will also be followed by healthcare providers you consult with by telephone (when your regular healthcare provider from our office is not available) who provide “call coverage” for your healthcare provider.

YOUR HEALTH INFORMATION

This notice applies to the information and records we have about your health, health status, and the healthcare and services you receive at this office. We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We must have your written, signed Consent to use and disclose health information for the following purposes:

- a) For Treatment.** We may use health information about you to provide you with the medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, office staff or other personnel who are involved in taking care of you and your health.

For example, your doctor may be treating you for a health condition and may need to know if you have other health problems that could complicate your treatment. The doctor may use your medical history to decide what treatment is best for you. The doctor may also tell another doctor about your condition so that doctor can help determine the most appropriate care for you. Different personnel in our office may share information about you and disclose information to people who do not work in our office in order to coordinate your care, such as phoning in prescriptions to your pharmacy, scheduling lab work and ordering X-rays. Family members and other healthcare providers may be part of your medical care outside this office and may require information about you that we have.

- b) For Payment.** We may use and disclose health information about you so that the treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health insurance plan information about a service you received here so your health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you are going to receive to obtain prior approval, or to determine whether your plan will cover the treatment.

- c) For Healthcare Operations.** We may use and disclose health information about you in order to run the office and make sure that you and our other patients receive quality care. For example, we may use your health information to evaluate the performance of our staff in caring for you.

We may also use health information about all or many of our patients to help us decide what additional services we should offer, how we can become more efficient, or whether certain new treatments are effective.

d) Appointment Reminders. We may contact you as a reminder that you have an appointment for treatment or medical care at the office.

e) Treatment Alternatives. We may tell you about or recommend possible treatment options or services that may be of interest to you. F

f) Health-Related Products and Services. We may tell you about health-related products or services that may be of interest to you.

Please notify us if you do not wish to be contacted for appointment reminders, or if you do not wish to receive communications about treatment alternatives or health-related products and services. If you advise us in writing (at the address listed at the top of this Notice) that you do not wish to receive such communications, we will not use or disclose your information for these purposes.

You may revoke your Consent at any time by giving us written notice. Your revocation will be effective when we receive it, but it will not apply to any uses and disclosures that occurred before that time. If you do revoke your consent, we will not be permitted to use or disclose information for purposes of treatment, payment or healthcare operations, and we may therefore choose to discontinue providing you with healthcare treatment and services.

SPECIAL SITUATIONS

We may use or disclose health information about you without your permission for the following purposes, subject to all applicable legal requirements and limitations:

To avert a Serious Threat to Health or Safety. We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Required by Law. We will disclose health information about you when required to do so by federal, state or local law.

Workers' Compensation. We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

Health Oversight Activities. We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for

certain state and federal agencies to monitor the healthcare system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.

Law Enforcement. We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.

Coroners, Medical Examiners, and Funeral Directors. We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

Information Not Personally Identifiable. We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

Family and Friends. We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment, that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you into the therapy room during treatment or while treatment is discussed.

In situations where you are not capable of giving consent (because you are not present or due to your incapacity or medical emergency), we may, using our professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, we will disclose only health information relevant to the person's involvement in your care. For example, we may inform the person who accompanied you to the emergency room that you suffered a heart attack and provide updates on your progress and prognosis. We may also use our professional judgment and experience to make reasonable inferences that it is in your best interest to allow another person to act on your behalf to pick up, for example, filled prescriptions, medical supplies, or medically related letters.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written *Authorization*. We must obtain your *Authorization* separate from any *Consent* we may have obtained from you. If you give us *Authorization* to use or disclose health information about you, you may revoke that *Authorization*, in writing, at any time. If you revoke your *Authorization*, we will no longer use or disclose information about you for the reasons covered by your written *Authorization*, but we cannot take back any uses or disclosures already made with your permission.

If we have HIV or substance abuse information about you, we cannot release that information without a special signed, written authorization (different than the *Authorization* and *Consent* mentioned above) from you. In order to disclose these types of records for purposes of treatment, payment or healthcare operations, we will have to have both your signed *Consent* and a special written *Authorization* that complies with the law governing HIV or substance abuse records.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding health information we maintain about you:

Right to Inspect and Copy. You have the right to inspect and copy your health information, such as medical and billing records, that we use to make decisions about your care. You must submit a written request to our Administrator in order to inspect and/or copy in **certain limited circumstances**. If you are denied access to your health information, you may ask that the denial be reviewed. If such a review is required by law, we will select a licensed healthcare professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

Right to Amend. If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by this office.

To request an amendment, complete and submit a Medical Record Amendment/Correction Form to our Secretary. We may deny your request for an amendment as long as the information is kept by this office. In addition, we may deny your request if you ask us to amend information that:

- a) We did not create, unless the person or entity that created the information is no longer available to make the amendment.
- b) Is not part of the health information that we keep.
- c) You would not be permitted to inspect and copy
- d) Is accurate and complete.

Right to an Accounting of Disclosures. You have the right to request an “an accounting of disclosures.” This is a list of the disclosures we made of medical information about you for purposes other than treatment, payment and healthcare operations. To obtain this list, you must submit your request in writing to the Administrator. It must state a time period, which may not be longer than six years and may not include dates before April 14, 2007. Your request should indicate in what form you want the list (for example, on paper or electronically). We may NOT charge you for the costs of providing the list the first time. We MAY charge you for the costs of providing the list subsequently. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or healthcare operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

We are NOT Required to Agree to Your Request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you may complete and submit the Request For Restriction On Use/Disclosure Of Medical Information to our Administrator.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you may complete and submit the Request for Restriction On Use/Disclosure Of Medical Information And/Or confidential Communications to our Administrator. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive it electronically, you are still entitled to a paper copy. To obtain such a copy, contact our Administrator.

CHANGES TO THIS NOTICE

We reserve the right to change this notice, and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a summary of the current notice in the office with its effective date in the top right hand corner. You are entitled to a copy of the notice currently in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact our Clinic Owner at 508-930-7162 You will not be penalized for filing a complaint.

Please sign that you have received this notice and have read and understood it's content:

Signature of client/guardian of minor child

Date

Print Name

TREATMENT CONSENT

Welcome to The Rested Mind LLC, counseling center. We will make every effort to be sensitive to your needs and assist you in addressing the concerns that brought you here. In order to help you, we believe it is important for you to understand our policies. Please read the items listed and sign this form below to acknowledge your awareness. Thank you.

- ❑ **Our hours are Monday through Thursday, 9AM to 8PM, Friday 9a-5p and Sunday 10a-6p (closed Saturday)** Client services phone consultations, psychological/psychiatric assessments, problem-focused counseling, referral to appropriate professionals, support and therapy groups, medication reviews, consultations and night/weekend crisis telephone coverage. A senior staff of psychologists, social workers and psychiatrists as well as supervised trainees in these fields provides these clinical services. We will try to fill any specific preferences you may have for a particular type of counselor (by gender, ethnicity, sexual orientation, etc.), although such requests may delay your first therapy session. **Our daytime phone number is 781-374-4100**
- ❑ **For emergencies only, which occur outside of routine office hours,** our On-call staff can be reached at **(617) 228-2805**. Please **do not call this number** for medication refill if you run out. You must come to your appointment for all prescription refills.
- ❑ Our staff makes every effort to respond to your communications and inquiries as promptly as we can, but in the course of a busy day we each receive numerous messages. If your therapist is not readily available, **unless you state that your call is “urgent”**, a message will be taken for your therapist who will return your call as soon as possible. *E-mail is used only for arranging appointments.* TheRestedMind@yahoo.com
- ❑ Our recommendations to you **may include referral to outside programs or therapists** when these seem advantageous to your care. Your personal health insurance will be expected to cover part of these treatment costs or you may have to pay for them “out-of-pocket”.
- ❑ **Medications** may be prescribed by a Psychiatrist or Nurse Practitioner with your agreement after a discussion of the benefits/risks of their use in your circumstances. We are prepared to re-evaluate your need for current or past psychiatric medications and, if appropriate, continue to prescribe these. We do not routinely prescribe medications for anyone not in therapy .
- ❑ The staff practices a **Limited Confidentiality**. This means that all the information you disclose to us will be treated as **private and confidential** and will be disclosed only with your permission by signing a Release of Information Form. Confidentiality is broken only in the circumstance where there is a perceived danger to the safety of you or someone else.
- ❑ We value your comments about our Service at any time. While we encourage you to address such issues directly with your counselor, you may certainly notify the owner of your concerns. After you have reviewed this form please sign below. If you have questions please ask your Counselor. You may have a copy of this form for future reference. We look forward to helping you achieve your life goals.
- ❑ In order for us to function properly and provide you the best service possible, it is important that you make every effort to make your scheduled appointment. There are always unforeseen circumstances. However, please call and let your provider know within the appropriate amount of time.

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*******Appointments cancelled in less than 24 hours are billed at \$100 dollars per missed visit. We reserve the right to terminate you as a patient if there are too many missed appointments as it will disrupt our ability to give you the best and safest care.**

Patients Signature: _____

Date:

Clinician: _____

Date:

Authorization Form

This form, when completed and signed by you, authorizes the release of protected information from your clinical record to the person you designate.

I, _____ (Patient's printed name), _____ (Patient's date of birth), authorize _____ (Therapist/Doctor's Name) at The Rested Mind, LLC counseling Center and/or his or her administrative and clinical staff:

- To **disclose** protected health information to the individual named below
- To **obtain** protected health information from the individual named below
- To **exchange** protected health information with the individual named below

Name of Individual _____ Phone: _____
Address _____ Fax: _____
City, State, Zip _____

Type of Information to be Disclosed/Obtained/Exchanged:

- Treatment Summary
- Diagnosis
- Psychological Testing Results
- Hospital Records
- Medication(s)
- Alcohol/Substance Use
- School/Education Records
- Appointments Kept

Other _____
(Provide a description of the information to be disclosed. The description should be specific and detailed.)

Purpose of Release: Coordination of Treatment
Other (please specify): * _____
*At the request of the individual is all that is required

Release Format(s) Verbal Communication
 Written
 Electronic Media (Fax) for urgent needs only

Expiration Date: _____ or until (event) _____
90 Days (date) (specify event)

You have the right to revoke this authorization in writing at any time by sending such written notification to the office address. However, your revocation will not be effective to the extent that we have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my psychologist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party. I have the right to copy and to inspect the information disclosed and have the right to receive the practitioner's Notice of Privacy Information Form.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of the information and may no longer be protected by the HIPAA Privacy Rule.

I have read and understand the above information and give my authorization voluntarily.

Patient Signature Date

Parent/ Guardian Signature Date

Parent/Guardian (Please Print Name)