PATIENT ID: _____

PATIENT INFORMATION				❑ ***New Patient*** ❑ ***Established PT***
Patient's FIRST Name: MIDDLE: LAST:				Social Security #:
Birth date: / /	Sex: ❑ M ❑ F	Marital status (circle one) Single / Mar / Div / Sep / Wid	Employment Status (circle one) Employed / Retired / Student / Not-Employed	Employer Name:
Your Address:		City		State: Zip Code:
Race: ❑Decline ❑White ❑American Indian /Alaska Nat. ❑Asian ❑Black/African American ❑Nat.Hawaii/Oth Pac Islander ❑Other		Ethnic Group: ❑Non-Hispanic ❑Hispanic/Latino ❑Decline		Language: ❑English ❑Spanish ❑Other: _____
Primary Phone#: ❑ Cell ❑ Work ❑Home ( )		Alternate Phone#: ❑ Cell ❑ Work ❑Home ( )		Email Address: Appointment reminder by email? ❑ Yes ❑ No
Referring Physician Name:		How did you hear about our office?		
Primary Physician Name:		Reason for visit:		

RESPONSIBLE PARTY:		
Person Financially Responsible [Guarantor] ❑ Self Only→Skip to insurance section ❑ Other Guarantor→Complete this section	Guarantor's Full Name:	Patient's Relationship to Guarantor: ❑ Child ❑ Spouse ❑ Other:
Address (if different):	Birth date: / /	Social Security #:

INSURANCE INFORMATION:			
Primary Insurance Company Name:	Plan Name:	Type of Plan: ❑ PPO ❑ POS ❑ HMO ❑ Medicaid ❑ Medicare ❑Tricare ❑ Medicare HMO ❑ WC ❑ Lien	
Claims Address:			Phone#: ( )
Policy#:	Group #:	Group Name:	
COPAY: $	Annual Deductible: $ ❑ Met ❑ Not Met ❑ Don't Know	Coinsurance: ❑ None (Plan pays 100%) ❑ 80/20 ❑ 90/10 ❑ 70/10 ❑ Don't Know	Effective Date: / /
Is plan thru employer? ❑ No ❑ Yes	Employer address:		Occupation:
Secondary Insurance Company Name:	Plan Name:	Type of Plan: ❑ Medicare Supplemental ❑ Medicaid ❑ Other Employer/Commercial ❑ Spouse's Plan (Pls. complete guarantor section) ❑ Other:	
Claims Address:			Phone#: ( )
Policy#:	Group #:	Group Name:	
Is plan thru employer? ❑ No ❑ Yes	Employer Name & Address:		

ACKNOWLEDGEMENT:

The above information is true to the best of my knowledge. I consent to the use and disclosure of my protected health information for treatment, payment and health care operations as described in this clinic's Notice of Privacy Practices. I authorize my insurance benefits be paid directly to Behavioral Healthcare Services as indicated on the claim. I understand that I am financially responsible for all fees and balances, regardless of insurance coverage.

Patient/Guardian signature: _____ Date _____

BEHAVIORAL HEALTHCARE SERVICES

Consent For Treatment

About Treatment
All services at Behavioral Healthcare are focused to assist you to identify problems with daily living, internal conflicts, and/or any addiction issues. By identifying these problems treatment is designed to help you cope more effectively.

Benefits and Risks of Treatment
Benefits of treatment include a better quality of life, awareness of strengths and limitations, and improved cognition. While working through difficult emotions, events, or memories you may experience a short period of discomfort in the course of treatment. It is important to keep your provider advised of any difficulty you may encounter.

Charges
Fees are based on the length and type of treatment. You will be responsible for the charges not covered. Fees are available upon request.

Confidentiality
Information discussed in session is contained in a confidential medical record at Behavioral Healthcare. I understand information may need to be disclosed by Behavioral Healthcare staff for the purpose of continuity of my care. Per state law, I understand information will be kept confidential with the exceptions of: abuse or neglect, potential harm to myself or others, or legal proceedings where a court order is issued to obtain records.

Right to Terminate Consent
I have the right to terminate my consent for treatment at any time. I understand I must submit the withdraw in writing to my provider.

I have read and understand the above. I understand I have the right to ask questions about this information at any time. By signing below, I consent for treatment to be provided by Behavioral Healthcare.

Signature of Patient or Legally Responsible Person	Name (Please print)
Relationship/Reason Why Patient Is Unable to Sign	Date
Witness	Date

BEHAVIORAL HEALTHCARE SERVICES

Financial Policy

Effective January 1, 2018 **Patient Name: _____**

Thank you for choosing Behavioral Healthcare Services as your health care provider. **Please carefully read and initial by each statement and sign below.** This policy has been put in place to ensure that financial payments due are recovered to allow us to continue to provide quality medical care for our patients. It is important that we work together to assure that payment for services is as simple and straightforward as possible. Our practice manager or billing department will be glad to discuss these policies with you.

1. _____ I understand that if I do not have my insurance card, referral, and / or co-payments, that my appointment may be rescheduled until such time that I can provide the required documents or payments.

2. _____ I understand that Behavioral Healthcare Services will collect all copayments at the time of visit and any procedure deductibles and coinsurance up to an amount equal to payment in full for the planned procedure code. Payment in full and expected coinsurance payment responsibility are determined by the anticipated billing code(s), details of your insurance policy, and agreement between your insurance company and Behavioral Healthcare Services. Any overpayment to your account will be refunded to you at your request after payment and/or remittance has been received from your insurance company.

3. _____ I understand that a $35 service fee will be added for any checks returned for any reason and I will be responsible for payment of this fee and the amount of the returned check. NSF checks must be redeemed with certified funds (cashier's check, money order, or cash.)

4. _____ I understand that if I am unable to make a scheduled appointment I need to contact Behavioral Healthcare Services at least 24 hours before my scheduled appointment time. Due to a high demand for appointments, missed appointments prevent us from scheduling appropriately and keep others in need of urgent care from being seen. **A $35 FEE WILL BE ASSESSED FOR ALL MISSED APPOINTMENTS & $50 FOR MISSED PROCEDURES NOT CANCELED WITH AT LEAST 24-HOUR ADVANCED NOTICE**.

5. _____ I understand that if my account is not paid in full within 90 days of a statement date, a 35% collection agency processing fee will be added to the outstanding balance and No additional appointments will be made for delinquent accounts until they are brought current.

6. _____ Behavioral Healthcare Services will allow 60 days from the date of filing for my insurance company to process or pay a claim. State law allows insurance companies operating in the state no more than 60 days to process claims. It is my responsibility to provide my insurance company with requested information needed to process a claim for services. It is also my responsibility to notify PRACTICE NAME if there is any change in my insurance coverage, residence, or phone number. ULTIMATELY, IT IS UP TO ME TO KNOW MY INSURANCE BENEFITS.

I have read and agree to all the provisions of the above financial policy. I understand that I am ultimately responsible for all professional fees incurred for professional services performed by the attending physician.

Signature of Responsible Party: _____ Date: _____

ASSIGNMENT OF BENEFITS

We require insured patients to complete assignment of benefits authorizing insurance to remit payment to provider's office.

I hereby assign all medical and /or surgical benefits to include major medical benefits to which I am entitled, private insurance, and any other health plans to: Behavioral Healthcare Services. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original**. I understand that I am financially responsible for all charges where or not paid by said insurance**. I hereby authorize said assignee to release all medical information necessary to secure the payment.

Signature of Responsible Party: _____ Date: _____

Behavioral Healthcare Services

435 Shrewsbury Street, Worcester, MA 01604,
TEL: 508-753-5554, FAX: 508-752-7245

HIPAA Notice of Privacy Practices

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

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for purposes required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information (PHI)

Your protected health information may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment. We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you; OR your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has necessary information to diagnose or treat you.

Payment. Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a medical procedure may require that your relevant protected health information be disclosed to the health plan to establish medical necessity.

Healthcare Operations. We may use or disclose, as needed, your protected health information in order to conduct normal operations of the physician's practice. These activities include, but are not limited to:

- Quality control
- Licensing
- Employee reviews
- Training of medical students

For example, we may disclose your protected health information to medical students that see patients in our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary to contact you for test results or to remind you of your appointment.

We may use or disclose your protected health information in the following situation without your authorization. These situations include: as Required By Law, Public Health Issues, Communicable Disease, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, law Enforcement; Coroners, Funeral Directors, and Organ Donation, Research, Criminal Activity, Military Activity and National Security, Workers' Compensation, Inmates, Required Uses and Disclosures, Under Lay, we must make a disclosure to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirement of section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization, or opportunity to object unless required by law.

Behavioral Healthcare Services

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in relation to the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your Protected Health Information.

You have the right to inspect and copy your Protected Health Information. Under federal law, however, you may not inspect or copy the following records – psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding.

You have the right to request a restriction of your Protected Health Information. This means you may ask us not to use or disclose any part of your Protected Health Information for the purpose of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care of for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restrictions, and whom they apply.

Your physician is not required to agree to a restriction that you may request. If physician believes your restriction is unreasonable and it is in your best interest to permit use and disclosure of your Protected Health Information, your Protected Health Information will not be restricted. If you wish, you then have the right to use another Healthcare Professional.

You have the right to request and receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e., electronically or by fax.

You may have the right to have your physician amend your Protected Health Information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your Protected Health Information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints – You may complain to the U.S. Department of Health and Human Services Government Center J.F. Kennedy Federal Building - Room 1875. Boston, MA 02203 if you believe your privacy rights have been violated by us; OR you may file a complaint with us by notifying our HIPAA Privacy Officer. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on January 01, 2018.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to Protected Health Information. If you have any objections to this form, please ask to speak with our privacy officer.

ACKNOWLEDGEMENT

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

Print Name_____Signature_____Date_____

CONTRACT FOR CONTROLLED SUBSTANCE PRESCRIPTIONS

Controlled substance medications (i.e., stimulants, narcotics, tranquilizers, and barbiturates) are very useful, but have high potential for misuse and are, therefore, closely controlled by the local, state, and federal government. They are intended to relieve symptoms, to improve function and/or ability to work, not simply to feel good. Because my physician is prescribing such medications for me to help manage my condition, I agree to the following conditions:

- I am responsible for my medications. If the prescription is lost, misplaced, or stolen, or if I use it up sooner than prescribed, I understand that it will not be replaced.
- I will not accept or request controlled substance medication form any other physician or individual while I am receiving such medication from the nurse practitioner. Besides being illegal to do so, it may endanger my health. The only exception is if it is prescribed while I am admitted in hospital.
- **Refills of controlled substance medication**:
    - Will be made only during my provider's regular office hours, in person, during a scheduled office visit. Refills will not be made by phone, at night, on holidays, or weekends.
    - Will not be made if I "run out early". I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining.
    - Will not be made as an "emergency", such as on Friday afternoon when I suddenly realize, "I will run out tomorrow" I will call at least 72 hours ahead if I need assistance with a controlled substance medication prescription.
- I understand that I may **not drink alcohol or use illegal drugs**. I agree to submit urine samples for screening if and when asked by my provider.
- I understand that prescription of controlled substance medication is intended to be temporary and that I must participate in the following additional treatments:
    - Weekly individual therapy or counselling with _____
    - _____
    - _____
- **I understand that if I violate any of the above conditions, my prescription and/or treatment with my provider may be ended immediately and I may be reported to medical facilities and other authorities.**

I have been fully informed by my provider regarding physiological dependence and the risk of addiction. I know that I will become physically dependent on the medication if I am on the medication for several weeks, and , when I stop the medication, I must do so slowly and under medical supervision or I may have withdrawal symptoms and possibly seizures.

I have read this contract and it has been explained to me by the provider. In addition, I fully understand the consequences of violating this contract.

Today's Date:_____

_____
Patient Name

_____
Patient Signature

_____
□Amjad Bahnassi, MD
□Michael Pizza, APRN-BC
□Kimberly Abdow, MS, NP-BC

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
		add columns	+	+

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

A2663B 10-04-2005

Request for Electronic Access and Authorization for Email Communication
PATIENT PORTAL

Patient ID: _____

Patient Name: _____DOB_____ Email: _____

Parent/Guardian Name: _____

I authorize Behavioral Healthcare Services to contact me using the email address provided above (including my name, information regarding my account balance and instructions for accessing the patient portal).

I understand that:

o the information is being sent for the purpose of communicating with me and allowing me to set up an account to access the patient portal,

o My name, provider number and account balance could be viewed by anyone who has access to my email and that if my email is unsecured, the information could potentially be intercepted. (However, information in the patient portal will only be accessible to someone who has the answer to certain questions that are expected to be known only to me.), and

o This authorization will be in force and effect until I terminate my relationship with the practice or revoke the authorization by making a request in writing to
Behavioral Healthcare Services at 435 Shrewsbury Street, Worcester, MA 01604 ATTN: Office Management

I further understand that:

• A revocation is effective only to the extent that the practice has not already relied upon it,

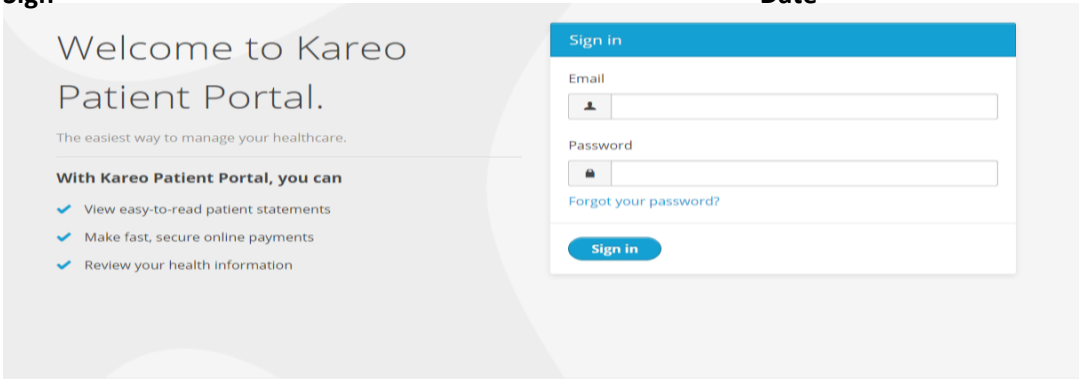
• Information used or disclosed pursuant to this authorization (name, email, practice name, account balance) may be used by a recipient of the email communication and then will be no longer protected by federal or state law,

• I can refuse to sign this authorization and the practice will not condition my treatment on whether I sign, and

• I have the right to inspect or copy my protected health information as permitted by federal and state laws.

_____ _____

Sign **Date**



TO BETTER SERVE YOUR CARE,
IT IS IMPORTANT YOU PROVIDE US YOUR **PRIMARY CARE PROVIDERS INFORMATION**

PLEASE FILL OUT THE FOLLOWING CONSENT PAGE OF YOUR **PRIMARY CARE PHYSICIAN**.
IF YOU ARE UNSURE OF WHO YOUR PRIMARY CARE PHYSICIAN IS, CONTACT YOUR INSURANCE COMPANY.

AUTHORIZATION FOR THE DISCLOSURE OF PROTECTED HEALTH INFORMATION

Full Name: _____ *Date Of Birth:* _____

Address: _____ *Home Phone:* _____ *Sex:* *M / F*

By signing this Authorization, I authorize the use or disclosure of my confidential and/ or Protected Health Information **maintained by: BEHAVIORAL HEALTHCARE SERVICES 435 Shrewsbury Street, Worcester, Ma. 01604**
My health information may be **disclosed** under this Authorization to:

PCP (Primary Care Provider)/AGENCY/PERSON: _____

ADDRESS: _____

PHONE; _____ **FAX:** _____

SCOPE OF USE OR DISCLOSURE: **PLEASE INITIAL** ALL THAT APPLY

_____ **All health information about me,** including my clinical records, including all psychiatric information created or received by the agency, for all dates of service.

_____ Initial here if you are allowing written and verbal **two-way communication** of protected health information between the people/parties listed above.

_____ Information pertaining to the identity, diagnosis, prognosis or **treatment for alcohol or drug abuse** maintained by a federally-assisted alcohol or drug program.

_____ Information regarding AIDS, ARC or HIV including, for example, a test for the presence of HIV antibodies or antigens, regardless of whether (i) this test is ordered, performed, or reported and (ii) the test results are positive or negative.

Specific health information ***including only*** (list specific dates of services if limited here: _____

PURPOSE OF THE USE OF DISCLOSURE: The purpose(s) of this Authorization is (are):
□Treatment Coordination and Planning □ Initiated by the Patient and the Patient does not elect to disclose its purpose.
Note: this box may NOT be checked if the information to be used or disclosed pertains to alcohol or drug abuse identity, diagnosis, prognosis or treatment.

This Authorization expires: (insert applicable event or date- mm/dd/yy) _____.
I have read and understand the terms of this Authorization. I have had an opportunity to ask questions about the use or disclosure of my health information. If I fail to specify an expiration date, event or condition, this authorization shall be valid for not more that the length of my care at Behavioral Healthcare Services, except when Federal and/or State regulations specify otherwise. In such situations, the shorter time period shall apply

Patient's Signature: _____ Date: _____

Witness: _____

When client is not competent to give consent, the signature of a parent, guardian, health care agent (proxy) or other representative is required. *
Signature of Legal Representative: _____ Date: _____

Print Name: _____
Relationship of Representative to Client: _____

*If signing as a legal representative, also provide appropriate paperwork to support status.

BEHAVIORAL HEALTHCARE SERVICES
435 Shrewsbury Street, Worcester, MA 01604
TEL 508-753-5554 FAX 508-752-7245
****A copy of completed authorization must be given to patient. ****

Behavioral Healthcare Services

435 Shrewsbury Street
Worcester, MA 01604
Tel: 508-753-5554
Fax: 508-752-7245

LETTER TO PRIMARY CARE PROVIDER

Date: _____

Address: _____
_____
_____

Fax Number: _____

Dear _____

I am writing to you on behalf of _____
(Print Name and Date of Birth)
to whom we are both providing services. I am sending along a copy of a signed consent to release confidential information form, and a behavioral health provider/ primary care provider communication form which I would like you to fill out and fax back to me at 508-752-7245. I have filled out Section A.

If you have any questions/concerns or would like to discuss our work with this client further please do not hesitate to contact me, I look forward to working with you as we collaborate to provide the best service that we can.

Sincerely,

_____

○Amjad Bahnassi, MD
○Kimberly Abdow, MS, NP-C
○Michael Pizza, APRN/BC

Combined MCE Behavioral Health Provider/Primary Care Provider Communication Form

Health Plan: Boston Medical Center HealthNet Plan Network Health Fallon Community Health Plan Neighborhood Health Plan PCC Plan HNE

The member below is currently receiving services and has consented to share the following information between his/her PCP and BH provider.

In an effort to increase communication and promote care coordination between providers, we ask that you review and/or complete the following health information.

Member name:_____ DOB:_____ Member ID#:_____

A signed copy of the release of information (ROI) must be attached to this form. Indicate date of expiration of ROI: _____

Section A: *(completed by BH Provider)*

1. The patient is being treated for the following behavioral health problem(s) and/or diagnoses: (list all)

2. The patient is taking the following medication(s): (list all prescribed and OTC medications, with dosage and frequency as applicable)

Prescriber: _____

3. The patient has the following substance abuse problem(s) (if applicable):

4. Please describe any special concerns:

Behavioral Health Clinician: _____

Behavioral Health Clinician Signature: _____

Provider Name/Site Name: Behavioral Healthcare Services

Address: 435 Shrewsbury Street

Worcester, Ma. 01604

Phone: 508-753-5554

Fax: 508-752-7245

Date this form completed:

Section B: *(completed by Primary Care Provider)*

1. The patient is being treated for the following medical problem(s) and/or diagnoses: (list all)

2. The patient is taking the following medication(s): (list all prescribed and OTC medications, with dosage and frequency as applicable)

3. The patient has the following BH (MH/SA) problem(s) (if applicable):

4. Please describe any special concerns (i.e., include abnormal lab results):

Primary Care Provider: _____

Primary Care Provider Signature: _____

Provider Name/Site Name: _____

Address: _____

Phone: _____

Fax: _____

Date this form completed:

To make a referral to Care Management, please call the members' plan at:

Boston Medical Center HealthNet Plan: (866) 444-5155 • Network Health: (888) 257-1986 • Fallon Community Health Plan: (888) 421-8861

Neighborhood Health Plan: (800) 414-2820 • Primary Care Clinician Plan: (617) 790-5633 • Health New England: (800) 786-9999

(Updated 9/20/2012)