

KERRY LUSIGNAN, MA, LMHC

PATIENT INTAKE FORM

Patient Name		Business Phone	
Street Address		Cell Phone	
Mailing Address		Email	
City		Social Security #	
State	Zip Code	Date of Birth	M or F
Home Phone		Marital Status: S M D W	
May I call you at any of the above numbers? Y or N		May I communicate with you via this email address? Y or N	
Primary Care Physician (PCP)		PCP Office Phone	
PCP Address			
Are you a full-time college student? Y or N		What school?	
During the past year, have you seen another provider for mental health services?		How many times?	
If you take any psychotropic medications, are they prescribed by your Psychiatrist, APRN, PCP, or Other? <i>Please circle one.</i>			

PRIMARY RESPONSIBLE PARTY

SECONDARY RESPONSIBLE PARTY

(This is the person responsible for paying any balances not covered by your insurance company.)

Name	
Mailing Address	
City	
State	Zip Code
Phone	

Name	
Mailing Address	
City	
State	Zip Code
Phone	

PRIMARY INSURANCE INFORMATION

SECONDARY INSURANCE INFORMATION

Insurance Company
Insurance ID#
Group#
Mailing Address
City, State, Zip
Phone
Subscriber's Name
Subscriber's Date of Birth
Subscriber's Social Security #
Subscriber's Employer
Relation to Patient
Copayment Amount \$

Insurance Company
Insurance ID#
Group#
Mailing Address
City, State, Zip
Phone
Subscriber's Name
Subscriber's Date of Birth
Subscriber's Social Security #
Subscriber's Employer
Relation to Patient
Copayment Amount \$

Do you have any form of MassHealth? Y or N If Yes, ID# _____

Please continue on the reverse side.

FOR OFFICE USE ONLY (To be filled out by the provider.)

DIAGNOSIS CODE(S):

SIGNATURE DATE: _____

1

2

3

4

KERRY LUSIGNAN, MA, LMHC

EMERGENCY CONTACT NAME:

HOME PHONE:

WORK PHONE:

CELL PHONE:

RELATIONSHIP TO YOU:

Consent to Treatment: I hereby consent to receive mental health treatment from Kerry Lusignan, MA, LMHC (hereafter referred to as Kerry.) I understand that my consent is voluntary. I also understand that I do not have to accept any treatment option Kerry offers and that I may withdraw my consent at any time.

Initials

Treatment Sessions: I understand that standard treatment sessions are 50 minutes in length, but that exceptions may occur. ***If I am unable to keep an appointment, I agree to notify Kerry at least 24 hours in advance. I understand that I will be charged the full session rate for all sessions cancelled with less than 24-hour notice.*** I also understand that Kerry may waive this fee in cases involving emergencies, but that such waiver is solely at her discretion.

Initials

Financial Obligation: I understand that I am responsible for full payment of all fees for services provided by Kerry regardless of whether there is insurance coverage. If I have insurance, I understand that I am responsible for knowing the specific terms and limits of my insurance coverage, and that I am ultimately responsible for full payment of fees. Furthermore, unless prior arrangements are made, I agree to pay any self-pay fees, copayments, and/or coinsurance amounts at the end of each session.

Initials

Billing Authorization and Release of Information: I hereby authorize Kerry to bill my insurance company for her services and to release my individually identifiable health insurance information necessary to process insurance claims. I understand that my individually identifiable health insurance information will also be released to Kerry's billing service, **Peace of Mind Billing Services**. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or healthcare provider, the released information may no longer be protected by federal privacy regulations.

Initials

Assignment of Benefits: I hereby authorize the payment of my insurance benefits directly to Kerry for services performed.

Initials

ACKNOWLEDGEMENT:

My initials above and signature below acknowledge that I understand and accept the terms and conditions of this authorization and agreement.

Patient Signature

Date

If the patient is a minor child, an appropriate guardian must sign below. Such signature acknowledges that this authorization and agreement applies to the minor child.

Parent/Responsible Party Signature

Relationship to Patient

Date

Kerry Lusignan, MA. LMHC.
Consent To Use and Disclose Your Health Information

This form is an agreement between you, _____ and Kerry Lusignan, MA. LMHC. When I use the word “you” below, it can mean you, your child, a relative, or other person if you have written his or her name here _____.

When I examine, test, diagnose, treat, or refer you I will be collecting what the law calls **Protected Healthcare Information (PHI)** about you. I need to use this information here to decide on what treatment is best for you and to provide any treatment to you. I may also share this information with others who provide treatment to you or need it to arrange payment for your treatment or for other business or government functions.

By signing this form you are agreeing to let me use your information here and send it to others. The Notice of Privacy Practices explains in more detail your rights and how I can use and share your information. Please read this before you sign this Consent form.

If you do not sign this consent form agreeing to what is in my Notice of Privacy Practices I cannot treat you.

In the future I may change how I use and share your information and so may change my Notice of Privacy Practices. If I do change it, you can get a copy from me,

If you are concerned about some of your information, you have the right to ask me to not use or share some of your information for treatment, payment or administrative purposes. You will have to tell me what you want in writing. Although I will try to respect your wishes, I am not required to agree to these limitations. However, if I do agree, I promise to do as you asked.

After you have signed this consent, you have the right to revoke it (by writing a letter to me telling me you no longer consent) and I will comply with your wishes about using or sharing your information from that time on but I may already have used or shared some of your information and cannot change that.

Signature of client or his or her personal representative

Date

Printed name of client or personal representative

Relationship to the client

Description of personal representative’s authority

Signature of authorized representative of this office or practice

Date of NPP _____ Copy given to the client/parent/personal representative.

NOTICE OF PRIVACY PRACTICES

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

Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

- "PHI" refers to information in your health record that could identify you.
- "Treatment, Payment, and Health Care Operations"
 - Treatment is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.
 - Payment is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
 - Health Care Operations are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "Use" applies only to activities within my office, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "Disclosure" applies to activities outside of my office, such as releasing, transferring, or providing access to information about you to other parties.

After you have read this notice you will be asked to sign a form indicating receipt of this notice as well as a separate Consent form to allow me to use and share your PHI. In almost all cases I intend to use your PHI here in my office or share your PHI with other people or organizations to provide **treatment** to you, arrange for **payment** for my services, or health care **operations**.

Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment, or health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your Psychotherapy Notes. "Psychotherapy Notes" are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorization (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- Child Abuse-If I, in the ordinary course of my profession, have reasonable cause to suspect or believe that any child under the age of eighteen years (1) has been abused or neglected, (2) has had nonaccidental physical injury, or injury which is at variance with the history given of such injury, inflicted upon such child, or (3) is placed at imminent risk of serious harm, then I must report this suspicion or belief to the appropriate authority.
- Adult and Domestic Abuse-If I know or in good faith suspect that an elderly individual or an individual who is disabled or incompetent has been abused, I may disclose the appropriate information.
- Health Oversight Activities-If a government agency is investigating my practice, I have to disclose some information.
- Judicial and Administrative Proceedings-There are some federal, state, or local laws which require me to disclose PHI.
 - i. If you are involved in a lawsuit or legal proceeding and I receive a subpoena, discovery request, or other lawful process I may have to release some of your PHI. I will only do so

after trying to inform you of the request, consulting your lawyer, or trying to obtain a court order to protect the requested information.

- ii. If you bring a lawsuit against me and disclosure is necessary or relevant to a defense, I may disclose the appropriate information.
- Serious Threat to Health or Safety-If I believe in good faith that there is risk of imminent personal injury to yourself or to other individuals or risk of imminent injury to the property of other individuals, I may disclose the appropriate information. I may also disclose PHI if it is necessary for you to be hospitalized for psychiatric care.
 - Worker's Compensation-I may disclose PHI regarding you as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

Patient's Rights and Therapist's Duties

Patient's Rights:

- Right to Request Restrictions-You have the right to request restrictions on certain uses and disclosures of PHI. However, I am not required to agree to a restriction you request.
- Right to Receive Confidential Communications by Alternative Means and at Alternative Locations-You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. On your request, I will send your bills to another address. Or, you may request that I not contact you at your work number.)
- Right to Inspect and Copy-You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. (You may be charged for the costs of copying and mailing this information.) I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.
- Right to Amend-You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. You have to make this request in writing and send it to me with the reasons you want to make the changes. I may deny your request. On your request, I will discuss with you the details of the amendment process.
- Right to an Accounting-When I disclose your PHI, I may keep some records of whom I sent it to, when I sent it, and what I sent. You generally have the right to receive an accounting of these disclosures of PHI.
- Right to a Paper Copy-You have the right to obtain a paper copy of this notice from me upon request.

Therapist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will send you a revised copy by mail.

Complaints

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you have the right to file a complaint with me and with the Secretary of the U.S. Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the level of care I provide you in any way.

Other Uses of PHI in Healthcare

- Business Associates- There are some jobs I hire other businesses to do for me. In the law, they are called Business Associates. Examples may include a copy service to make copies of your health records or a billing service to print, mail, and follow-up on my insurance claims for reimbursement, to mail patient bills, and/or to contact your insurance company regarding benefits, eligibility, and authorization. These business associates need to receive some of your PHI to perform their jobs properly. To protect your privacy they have agreed in a signed contract to safeguard your information.

The effective date of this notice is April 14, 2003.

KERRY LUSIGNAN, LMHC

NOTICE OF PRIVACY PRACTICES

CLIENT NAME

CLIENT DATE OF BIRTH

THE SIGNATURE BELOW INDICATES THAT I HAVE RECEIVED A COPY OF THE NOTICE OF PRIVACY PRACTICES FROM (PROVIDER NAME):

SIGNATURE OF CLIENT OR GUARDIAN

DATE

GUARDIAN'S NAME (*Please print*)

RELATIONSHIP TO CLIENT

Kerry Lusignan, MA, LMHC
94 King Street 2D
Northampton, MA 01060
413-626-4707

**CANCELLATION
AND
MISSED APPOINTMENT
POLICIES**

EFFECTIVE JANUARY 1, 2006

Effective January 1, 2006, all patients will be required to give at least ***24-hour notification*** if you are unable to keep an appointment. You will be automatically charged the full session fee for any missed appointments that are cancelled with less than 24-hour notice.

This fee may be waived in cases involving emergencies, but such a waiver is solely at my discretion.

Thank you for your understanding and cooperation.

The signature below acknowledges that I understand and accept the terms and conditions of this policy.

Patient's Printed Name

Patient's (or Guardian's) Signature

Date

This cancellation policy replaces any previous cancellation policies.