South Shore
CHILD AND FAMILY COUNSELING

639 Granite Street, Suite 303 Braintree, MA 02184
Phone: 781-817-5844
Fax: 781-817-5724
www.sscfc-braintree.com

CLIENT INFORMATION

First Name _____ Last Name _____

Street Address _____

City _____ State _____ Zip Code _____

Birthdate _____ Social Security Number _____ Gender _____

Home Phone _____ May we leave a detailed message on your home phone? ☐ Yes ☐ No

Cell Phone _____ May we leave a detailed message on your cell phone? ☐ Yes ☐ No

Marital Status ☐ Single ☐ Never married ☐ Married

☐ Separated ☐ Divorced ☐ Widowed

Occupation/Employer and/or School _____

Spiritual Affiliation _____

EMERGENCY CONTACT INFORMATION

First Name _____ Last Name _____

Relationship _____ Phone # _____

Street Address _____

City _____ State _____ Zip Code _____

INSURANCE INFORMATION

Primary Insurance _____

Subscriber Name _____ Subscriber Date of Birth _____

Primary Insurance ID No. _____ Group Number _____

☐ No secondary insurance

Secondary Insurance _____

Subscriber Name _____ Subscriber Date of Birth _____

Primary Insurance ID No. _____ Group Number _____

RELEVANT CLIENT INFORMATION

FAMILY BACKGROUND

Please list the members of your family currently living with your, their genders, their occupations, and their ages.

Family Member Name	Relationship	Gender	Occupation	Age

Please list any family history of mental illness

Please list any family history of substance abuse

Please list previous **medical history**, including dates of any medical hospitalizations

Please list all medication you are currently taking (prescribed and over-the-counter medication).

Medication	**Dosage**	**Frequency**	**Prescriber**
Zoloft	*100 mg*	*Daily*	*Dr. John Doe*

List all previous psychiatric treatment you received, including dates of any hospitalizations and prior counseling.

List past and current substance abuse history.

Do you use nicotine products (include cigarette, e-cig, vaporizer, and chewing tobacco use)?

☐ No ☐ Yes If yes, how much and how frequently do you use?

Please tell us why you are seeking treatment at this time.

How did you hear about South Shore Child and Family Counseling? _____

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

_____ _____

Signature (Client or Guardian) Date

OFFICE POLICIES AND PROCEDURES

AUTHORIZATION FOR RELEASE OF INFORMATION TO INSURANCE COMPANIES

South Shore Child and Family Counseling, LLC and all business partners are authorized to release billing information which may include name, date of services, types of services, diagnosis codes, substance abuse information and/or treatment plans to your insurance company/companies for the purpose of collecting insurance payments or for authorization of additional sessions. South Shore Child and Family Counseling, LLC and its providers are authorized direct payment for behavioral health and substance abuse services provided.

PATIENT FINANCIAL RESPONSIBILITY FORM

South Shore Child and Family Counseling, LLC will submit all claims to your insurance company on your behalf. You understand that you will be responsible for any co-payments, deductibles, and payment for any services not covered by your insurance company. You will also be responsible for any charges incurred by not attending the most current and correct scheduled appointment. Additionally, you understand that co-payments and deductibles are due at time of each visit. If you have used a check as a payment and the check is returned, you are responsible for your current payment as well as a charge of $25 for the returned check.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, we have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. In most collection situations, the only information we release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due.

Note: There may be exceptions to this policy for Federal and State funded insurance plans such as MassHealth, Medicare and Medicaid. Please check with your insurance company for clarification.

SELF-PAY FEES

South Shore Child and Family Counseling, LLC will charge the fees identified below should you choose not to use your insurance or services you seek are not covered by your insurance company.

Diagnostic Evaluation (60 minutes)	$150
Individual Session (45 minutes)	$120
Individual Session (30 minutes)	$60
Family/Couples Therapy (45 minutes)	$130
Group Therapy (60 minutes)	$35
Telephone/In Person Consultation (15 minute increments)	$30
Late Cancellation/No Show (less than 24 hour notice)	$65

If it becomes necessary to prepare a summary of your records you will be charged an appropriate fee. The fee schedule to release a completed protected clinical records is as follows:

1-3 pages	$5.00
4-10 pages	$10.00
11-25 pages	$25.00

THERAPY HOUR

The "therapy hour" at South Shore Child and Family Counseling, LLC is typically forty-five (45) minutes in length unless an alternative plan has been made with you. Your clinician is expected to begin and end your session on schedule. There are times when demands of a phone consult or an urgent situation may make your clinician temporarily behind schedule. You

can count on having your full scheduled 45 minutes available to you. If you would like to extend your session to more than 45 minutes, you are able to do so, but this will not be charged to the insurance company and there will be a fee.

CANCELLATIONS

When you schedule an appointment with a therapist at South Shore Child and Family Counseling, we set aside an appointment slot just for you. We do not get paid for that appointment unless you are present for your session and we collect our fee from you or your insurance company. Cancellations and No Shows interfere with the continuity of counseling and present many scheduling problems. We ask that you please give at least twenty four (24) hours notice to cancel or reschedule your appointment. Cancellations with less than 24 hour notice are subject to a $65.00 charge unless your health insurance indicates otherwise, extreme weather prevents your ability to travel, or you have a medical emergency. Appointments canceled at the request of the provider will be rescheduled with no late fees incurred to you.

CONSULTATION/CARE COORDINATION

Clinicians may occasionally consult with other clinicians at South Shore Child and Family Counseling, LLC about services provided and this person is bound by the same laws regarding confidentiality.

If you are a client at South Shore Child and Family Counseling, LLC please be informed that your clinician may discuss your treatment with other clinicians within South Shore Child and Family Counseling, if appropriate for the purpose of treatment planning and care coordination.

CASE MANAGEMENT

During the course of treatment your clinician may be available to consult with current and former providers of care with your written permission. This may include physicians, psychiatrists, teachers, etc. If the need arises, reports or documents relevant to your care will be reviewed. This may include psychological testing, court documents or hospitalization records. If the case management becomes lengthy or excessive, there will be a fee for services not covered by your insurance company. This may include: lengthy phone consultations, reviewing extensive reports, preparing documents and assessments/evaluations or attending team/educational meetings.

COURT RELATED MATTERS

We do not provide or perform evaluations for custody, visitation or other forensic matters. Therefore, it is understood and agreed that we cannot and will not provide any testimony or reports regarding issues of custody, visitation or fitness of a parent in any legal matters or administrative proceedings.

If we are contacted by an attorney regarding your treatment (either at your behest or related to a legal matter you are involved in), please note the following:

- We charge a $2000 retainer prior to any preparation or attendance of legal proceedings.
- We charge $200/hour to prepare for and/or attend any legal proceeding and for all court related services.
- Charges for court related services are not covered by insurance.
- Court related services include: talking with attorneys, preparing documents, traveling to court, depositions and court appearances.
- If the court or attorneys do not pay our fee, you will be charged for the time we spend responding to legal matters.
- You will also be charged for any costs we incur responding to attorneys in your case, including but not limited to fees we are charged for legal consultation and representation by our attorneys.

AFTER HOURS COVERAGE

If you need to reach the office after hours or you are experiencing a psychiatric crisis, please contact our on-call phone number at (781) 519-9084.

COMPLAINTS

If you have a concern or complaint about your treatment or about your billing statement, please talk to us about it. We will take your criticism seriously, openly, and respond respectfully. To voice your concerns, please contact the practice owner, Lujuana Milton, directly at (781) 817-5844.

QUESTIONS

If during the course of your therapy, you have any questions about the nature of your therapy or about your billing statement, contact the office directly.

CHANGES TO POLICIES AND PROCEDURES

We reserve the right to change our policies and procedures. We reserve the right to make the revised or changed policies and procedures effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current policies and procedures in the office and will offer you a copy of the current Notice in effect.

YOUR INFORMATION. YOUR RIGHTS. OUR RESPONSIBILITIES.

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.

YOUR RIGHTS	YOUR CHOICES	OUR USES AND DISCLOSURES
You have the right to: • Get a copy of your paper or electronic medical record • Correct your paper or electronic medical record • Request confidential communication • Ask us to limit the information we share • Get a list of those with whom we've shared your information • Get a copy of this privacy notice • Choose someone to act for you • File a complaint if you believe your privacy rights have been violated	You have some choices in the way that we use and share information as we: • Tell family and friends about your condition • Provide disaster relief • Include you in a hospital directory • Provide mental health care • Market our services and sell your information • Raise funds	We may use and share your information as we: • Treat you • Run our organization • Bill for your services • Help with public health and safety issues • Do research • Comply with the law • Respond to organ and tissue donation requests • Work with a medical examiner or funeral director • Address workers' compensation, law enforcement, and other government requests • Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice
You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you
- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated
- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.
In these cases, you have both the right and choice to tell us to:
- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:
- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:
- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.
- **Treat you**

We can use your health information and share it with other professionals who are treating you.
Example: A doctor treating you for an injury asks another doctor about your overall health condition.
- **Run our organization**

We can use and share your health information to run our practice, improve your care, and contact you when necessary.
Example: We use health information about you to manage your treatment and services.
- **Bill for your services**

We can use and share your health information to bill and get payment from health plans or other entities.
Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Office Policies and Procedures

Please ask before signing below if you have any questions about psychotherapy or our office policies and procedures. Your signature indicates that you have read South Shore Child and Family Counseling's Office Policies and Procedures and agree to enter therapy under these conditions. Your signature below indicates that you are making an informed choice to consent to therapy and understand and accept the terms of this agreement.

I have read and agree to the terms in the outpatient services contract.

Client Name: _____

Guardian Name (if minor) _____

Client/Guardian Signature: _____ Date: _____

Notice of Privacy Practices

I have read the notice of privacy section.

Client Name: _____

Guardian Name (if minor) _____

Client/Guardian Signature: _____ Date: _____

CREDIT/DEBIT/FLEXIBLE SPENDING CARD ON FILE

All payments are due on the day of service. In lieu of paying at each session, South Shore Child and Family Counseling, LLC will charge your payments on the day of your appointment (by the end of business day).

All clients of South Shore Child and Family Counseling, LLC are required to have a card on file in order to pay for any copayments, co-insurance, deductibles, no shows/late cancellations or out of pocket expenses.

All cards will be charged at the end of the day of your appointment. Please be aware that we will only notify you prior to your card being charged for any payments above $65.00.

A receipt of your payment is available by request and will be made available to you.

Your card information will be stored in a HIPAA compliant electronic health system and this document will be safely destroyed.

Please note: If your health insurance does not require payments, you are not required to have a credit card on file.

Please complete the information and sign below:

Client name: _____

Card Holder Name: _____

Card Number: _____

Expiration Date: _____ Billing Zip Code of Card: _____

Security Code (3 digits on back of card, 4 digits on front if AmEx): _____

Card Holder's Signature: _____ Date: _____

I understand that by signing above, I am authorizing South Shore Child and Family Counseling, LLC to charge my card in the manner indicated. These balances may include co-payments, co-insurance amounts, out of pocket payments, deductibles, no show or late cancellation fees. I understand that South Shore Child and Family Counseling will provide a receipt as proof of payment by request.

Behavioral Health Provider/Primary Care Provider Communication Form

TO BE COMPLETED BY CLIENT/PARENT OR GUARDIAN OF CLIENT

If you are a client at South Shore Child and Family Counseling, LLC please be informed that this document allows your clinician to discuss your treatment with your Primary Care Physician for Care Coordination purposes only unless otherwise provided with written permission.

Client Name: _____ Birthdate: _____ SSN: _____

Physician's Name: _____ Phone: _____

Physician's Address: _____ Fax: _____

☐ By checking this box, I do not give permission to send this document to my Primary Care Physician.

Signature (Client/Parent or Guardian of Client): _____ Date: _____

TO PRIMARY CARE PHYSICIAN

The client above has consented to share the following information below between their Primary Care Physician and Behavioral Health 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.

TO BE COMPLETED BY CLINICIAN ONLY	**TO BE COMPLETED BY PCP ONLY**
1. The client is being treated for the following behavioral health problem(s) and/or diagnosis: _____ _____	1. The client is being treated for the following behavioral health problem(s) and/or diagnosis: _____ _____
2. The client is taking the following medications (list prescribed AND OTC, dosage, frequency, and prescribers as applicable): _____ _____ _____	2. The client is taking the following medications (list prescribed AND OTC, dosage, frequency, and prescribers as applicable): _____ _____ _____
3. The client has substance use problem(s) (if applicable): _____ _____	3. The client has substance use problem(s) (if applicable): _____ _____
4. Please describe any special concerns: _____ _____	4. Please describe any special concerns: _____ _____

Behavioral Health Clinician Name (PRINT): _____

Behavioral Health Clinician Signature: _____ Date: _____

Primary Care Physician Signature: _____ Date: _____

Informed Consent for Treatment of Children and Adolescents

Only a legal parent or guardian can consent to the treatment of a minor child. Stepparents and foster parents cannot consent to treatment, but may schedule the initial sessions.

Standard paperwork must be sent to the legal parent/guardian prior to the intake appointment. This includes the following:

- Client Intake Form
- Office Policies and Procedures
- Notice of Privacy Practice
- Authorization for Release of Information
- Primary Care Physician Release of Information

Parents are asked to provide all contact information of the non-custodial parent so that paperwork can be sent to them.

Both legal parents of the child must consent to the ongoing treatment of the minor child with South Shore Child and Family Counseling, LLC.

If either parent request that the therapy be discontinued, the therapist will inform the other parent of this request and therapy will be discontinued immediately. *This rescinding of treatment or of consent must be in writing from the parent who is making this request.*

If the non-custodial or other parent asks for information regarding the child in therapy, the therapist will provide a summary of treatment, including presenting problem, dates of sessions, and general treatment plan, as long as his/her parental rights are intact.

FOSTER PARENT SEEKING TREATMENT FOR THE CHILD(REN)

Foster parents must bring to the initial appointment all required paperwork and consents signed by the legal parent or the Department of Children and Families (if the Department of Children and Families is granted limited guardianship for the purpose of medical, educational, and mental health treatment). In some situations, the court may appoint the Guardian Ad Litem for such purposes. Please check your child's DCF caseworker about who has legal guardianship to sign the required paperwork.

ADOPTIVE PARENT SEEKING TREATMENT FOR THE CHILD(REN)

Adoptive parents need to bring the termination order and adoption order indicating the finalization of the adoption and that legal guardianship falls with the adoptive parent. If the adoption has not been finalized, the appropriate DCF designee or whoever holds the temporary legal guardianship of the child should sign the paperwork prior to the initial appointment.

STEPPARENTS SEEKING TREATMENT FOR THE CHILD(REN)

Stepparents cannot consent to the treatment of a stepchild. They cannot rescind consent for the treatment unless there is court documentation giving that stepparent limited guardianship that specific purpose. Stepparents would need to obtain proper consents from both legal parents as well as obtain a release of information in order to seek treatment for the child.

CHILD/ADOLESCENT SERVICES

Child/adolescent therapy may involve disagreements among parents and/or disagreements between parents and the clinician regarding the best interest of the child. If such disagreements occur, your clinician will strive to listen carefully so that they can understand your perspectives and fully explain theirs.

Therapy is most effective when a trusting relationship exists between the clinician and the client. Privacy is especially important in securing and maintaining that trust. It is often necessary for children to develop a "zone of privacy" whereby they feel free to discuss personal matters with greater freedom. This is particularly true for adolescents who are naturally developing a greater sense of independence and autonomy. Further, you understand that the clinician's involvement will be strictly limited to that which will benefit your child. As a parent of a minor child/adolescent you are always entitled to the following information: current physical and mental condition, diagnosis, treatment needs, services provided, and services needed.

If your child is under 18 years of age, please be aware that the law may provide parents the right to examine their child's treatment records. In some cases you may not be able to examine the child's treatment records even if they are under the age of 18, in such cases if the child does not object or the clinician does not find that there is a compelling reason for denying the access to the records, then the records will be provided for examination. In all instances, clinician reserves the right to withhold the examination of the child's records if in the clinician's opinion it is in the child's best interest.

By signing below, I am indicating that I have read, understand, and agree to what is outlined above as it pertains to Informed Consent for the treatment of my child, _____ (child's name).

_____ _____

Signature of Parent or Guardian Date

Legal Guardian Statement Form

Sole legal custody means the condition under which one person has legal custody of an individual who is a minor. **Joint legal custody** means the condition under which parent(s) and/or court appointed legal guardian(s) share legal custody and no parent or guardian has superior rights, except with respect to specified decisions as set forth by a court of law or the parents or guardians in a final judgement or court order. **Joint physical custody** means the condition under which the physical residence of the minor is or is not shared by the parent(s) and/or court appointed legal guardian(s).

No parent, stepparent, grandparent, foster parent or other adult who may be delivering legitimate care to the minor, but otherwise has no legal custody rights to minor, shall sign this statement. This statement can be signed individually or jointly by any parent or guardian who has legal custody rights.

If anything should change concerning my legal rights to the minor child, I will inform South Shore Child and Family Counseling, LLC immediately. South Shore Child and Family Counseling, LLC shall not be held responsible for the failure of any party to inform South Shore Child and Family Counseling, LLC of any inaccurate custody information or subsequent changes to custody information.

I hereby attest that I am the legal guardian of, _____, and am seeking therapeutic services for my minor child through South Shore Child and Family Counseling, LLC.

_____	_____
Printed Name of Parent or Guardian	Printed Name of Parent or Guardian
_____	_____
Signature of Parent or Guardian	Signature of Parent or Guardian
_____	_____
Date	Date