MERRIMACK VALLEY COUNSELING ASSOCIATION
Northcrest Executive Office Park •39 Simon Street, Unit #2A •Nashua, NH 03060 •(603)888-4347 • Fax (603)577-9157

Minor/Child Information Form

Patient Name: _____ DOB: _____ Age:_____

Address: _____ City, St, Zip _____

Phone#: _____(H) _____(C) if applicable

Parent Name(s): _____email:_____

Who does the child reside with?

School Name and Telephone Number:

Non-custodial parent information, if applicable:

Does the non-custodial parent have a legal right to approve or disapprove treatment for their child? Yes ☐ No ☐

If yes, does he/she approve the treatment that will be rendered by Merrimack Valley Counseling Association? Yes ☐ No ☐

If no, we will be unable to provide services until both parents agree to treatment.

If yes, please have the non-custodial parent complete the following:

Name _____ Phone: _____

Address: _____

My signature below indicates my agreement with treatment provided by Merrimack Valley Counseling Association for my child _____. I understand that I may revoke this authorization, in writing, at any time.

_____ _____

Non-Custodial Parent [Electronic]Signature *Date*

Primary Insurance Subscriber Information:

Name: _____DOB: _____ Relation: _____

Insurance Company: _____ ID#_____ Employer: _____

Secondary Insurance Subscriber Information:

Name: _____ DOB: _____ Relation: _____

Insurance Company: _____ ID#_____Employer: _____

Emergency Contact Information:

Name: _____ Phone#: _____ Relation: _____

Current Primary Care Physician:

Name: _____ Phone#: _____

Address: _____

Medical Conditions: _____

Medications:_____

Pregnancy, Birth and Development:

Were there any problems during pregnancy?

Were there any problems at the time of birth or during the post-natal period?

Did development occur within normal limits?

Please summarize your reason(s) for seeking counseling:

Statement of Confidentiality:

Within certain limitations, information by you and (if applicable) your child(ren) during the course of treatment will be kept strictly confidential and will not be revealed to any other person and/or agency without your written consent. At your request, any or all parts of your records can be released to any person and/or agency you designate in writing. There are certain situations in which Psychologists, mental health professionals and/or medical professionals are required by law to reveal information without your permission. These include:

- Clear suspicion that physical abuse, sexual abuse or physical neglect has occurred to a minor.
- Grave bodily harm or death is threatened to another person
- Serious suicidal intentions are conveyed and a client or their guardian refuses voluntary treatment to ensure the patient's safety
- When a court of law issues a subpoena for information obtained during treatment in response to the order of a court of law
- Reporting as mandated by HIPPA, The Health Insurance Portability and Accountability Act.

If you have questions and/or concerns regarding your rights to confidentiality, please discuss them with your mental health professional at the time of your appointment.

Psychological and Neuropsychological Testing

For psychological and neuropsychological assessments, you are responsible for paying the fees for report writing and scoring. The fee is $175 an hour for report writing and scoring. We require an up-front minimum down payment of $500 before testing will be scheduled. Based on the complexity and depth of the assessment, additional hours may be required for scoring and report writing, which is the responsibility of the client/patient. If your health insurance policy does pay for psychological assessments, report writing, etc., Merrimack Valley Counseling Association will reimburse you for any monies we receive from your insurance for testing, scoring and report writing. You will be responsible to pay any remaining balance before test results and written assessments will be released to you or any school or agency requesting them.

If in agreement, please sign and date.

Signature*: _____ Date: _____ Relation to Patient: _____

Parent or Legal Guardian

**The parties agree that this agreement may be electronically signed. The parties agree that the electronic signatures appearing on this agreement are the same as handwritten signatures for the purposes of validity, enforceability, and admissibility.*

Client's/Patient's Rights

I acknowledge that my child and I have received or been offered a copy of the patient's Mental Health Bill of Rights and a copy of the HIPAA privacy laws.

_____ _____
*Signature** *Date*

Safety Contract

As the parent or legal guardian of _____ (child's name), I contract to call his/her therapist if I feel he or she is engaging in any self-destructive behaviors that would place my child or others in imminent danger. If my child's therapist is not available, I agree to speak to the on-call therapist. If no direct contact is available, I agree to call 911 or take my child to the nearest hospital emergency room.

Southern NH Medical Center	Tel. (603) 577-2000 or (603) 577-2728
St. Joseph's Hospital	Tel. (603) 882-3000

This contract shall remain in effect for as long as my child remains in treatment.

[electronic] Signature*:_____ _____
Parent or Guardian Signature, Relation to Patient *Date*

Notice to Clients and Consent to Treatment Agreement

The Board of Mental Health Practice and Board of Psychologists regulations including the Mental Health Bill of Rights, require all licensed Mental Health professionals to provide clients certain basic information. Also, to avoid confusion or misunderstandings, we are providing additional important information about our practice for your review and agreement. Please read carefully and discuss any questions before initialing and signing below.

1. ***Provider Qualifications and scope of practice*:** Each provider will be happy to provide you with his/her qualifications and scope of practice. This information is also available via Merrimack Valley Counseling Association Brochures and website (https://www.merrimackvalleycounseling.org/) This information is also available via Merrimack Valley Counseling Association Brochures and website (https://www.merrimackvalleycounseling.org/) under the tab <CLINICIANS>. Our providers are licensed psychologists, licensed mental health counselors, licensed clinical social workers, licensed nurse practitioners, or licensed psychiatrists and we are governed by the Code of Ethics of the American Psychological Association, American Mental Health Counselors Association, Clinical Social Work Association, American Nurses Association or American Psychiatric Associations. Our NH licenses are generally displayed in the office where we most often practice and are available at all times. A copy of each ethics code is also available in our waiting room. Each provider will provide information regarding his/her training, qualifications, and experience at the initial meeting and upon request._____ (initials)

2. ***Mental Health Bill of Rights***: Pursuant to the NH Mental Health Bill of rights, clients have certain rights. A copy of the Mental Health Bill of Rights is included with this form and posted in the waiting area. Please review the Bill of Rights carefully and let us know if you have any questions. I acknowledge that I have received or been offered a copy of the Mental Health Bill of Rights and a copy of the HIPAA privacy laws**.** _____ (initials)

3. ***Diagnosis and Recommended Treatment:*** As part of your (your child's) treatment, your provider will discuss your (your child's) diagnosis, proposed treatment plan, including an estimate of length of therapy, likely benefits and risks and available alternatives. Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience, uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience. You should be aware that there are alternative types of services to those being offered by your practitioner. You may prefer to obtain services from someone other than your provider. You also have choices not to obtain any services. There are also risks and benefits associated with not pursuing any services. To the extent that you are interested in alternatives, you should discuss this with your provider. By signing this agreement, you are consenting to treatment with your provider. _____ (initials)

4. ***Confidentiality***: Under New Hampshire law, communications between a client and licensed mental health provider (including on-call clinicians) are privileged/confidential and may not be disclosed without specific authorization of the client except under specific, limited circumstances. For example: Privilege does not apply in a civil commitment proceeding (involuntary hospitalization) in which the issue is whether the individual is a danger to self or others or when a client is seeking treatment relating to a worker's compensation claim. Privilege does not apply in circumstances in which a client has filed a complaint with the governing board or a malpractice suit. Privilege does not apply to providing information to obtain payment for services from an insurance carrier (per client's agreement to receive/use insurance to cover the cost of services). Records may also be subject to audit by regulatory authorities. Among the exceptions to confidentiality, are New Hampshire reporting laws which require licensed mental health practitioners to report to the appropriate authorities certain types of conduct including suspected abuse, neglect, and exploitation of children and incapacitated adults. Licensed mental health practitioners are also required to warn the police or likely victims of serious threats of physical violence to a person or property. Your provider may release limited information without your consent to build a "safety net" to prevent suicide. On-call clinicians may provide information to your treating clinician to assist in follow-up with your care at upcoming appointments. As part of maintaining a valid license, you provider is required to discuss cases with colleagues. We may also obtain formal supervision on certain cases when we believe it is necessary. In these situations, we do not disclose the identity of the client. Our colleagues are, of course, legally bound to confidentiality as well. By signing this document, you are acknowledging that you understand that we may discuss your case in consultation and/or supervision and do not object to us doing so. _____ (initials)

5. ***Court Ordered Treatment***: If you are seeing a provider due to a court order requiring you to seek treatment, it is our policy that we not proceed with treatment until we have received a copy of the court order and have an opportunity to review it. Because you have been ordered by the court to obtain treatment, there are limits to confidentiality in addition to the ones described above. For example, your provider may be obligated to file a report with the court that ordered you to seek treatment or with someone else. _____ (initials)

6. **MINORS**: Generally the treatment of a minor child (under the age of 18) must be authorized by a parent or someone else with legal authority. Parental control over a minor's treatment includes the authority to access or release the child's otherwise confidential treatment records. Even parents without residential responsibility (i.e., when the child is not living with the parent) for a child retain decision-making authority over the child's treatment and treatment records unless a court has ordered otherwise. When parents with decision-making authority cannot agree on access to or release of their child's confidential treatment information, a court will decide following a hearing. We believe it is best to identify and resolve potential parental agreements before treatment begins. Therefore, it is our policy to treat minors only with the consent of both parents, to the extent that both are available. If both are available but cannot reach agreement about treatment and access to records, it is the responsibility of parents to resolve their differences though a court hearing prior to instituting treatment. If one parent is unavailable and we determine that it is appropriate to proceed with the consent of only one parent, the absent parent will have a right to the child's treatment records upon request while the child is a minor unless there is a court order to the contrary. If continuation of treatment becomes an issue, it is the responsibility of the parents to resolve the disagreement in court. In New Hampshire, all information regarding your child's therapy record is considered privileged and therefore can only be released in limited

circumstances. If there is a dispute about whether your child's records should be released, the court must determine what is in the child's best interests. It is your responsibility to ensure that this issue is brought to the court's attention. As your child's provider, we will be unable to provide therapy records to anyone until the court has determined what is in the child's best interest. Upon turning 18, the child gains control over treatment, information and records. In general, to preserve trust in the therapeutic relationship and encourage young people to openly express themselves in therapy, your child's provider will keep the contents of sessions with minors confidential and will only share safety concerns with parents. Parents may communicate any concerns they believe will help the young person's wellbeing by phoning your child's clinician or checking in with the clinician and the minor client at the beginning of any session. By signing this agreement, you are consenting to your child's treatment. _____ (initials)

7. ***Conflicts of Interest***: New Hampshire is a small state. From time to time, actual or potential conflicts of interest may arise. In the event that your provider becomes aware of a conflict of interest in providing treatment to you, we may be required to refer you to another provider. Regardless of any conflict of interest, you can be assured that any information will remain confidential. _____ (initials)

8. ***Couples/Families*:** Treatment records of couples/family sessions contain information about each person. All clients should be aware that each person has a right to obtain treatment records unless both clients agree that treatment records will only be released by joint consent. MVCA will generally not release couples/family records without consent of all family members who have reached the age of majority without a court order. _____ (initials)

9. ***Group Therapy***: Unlike individual treatment, confidentiality of group therapy is not privileged, and therefore is not protected by law. Group members must sign and abide by a written confidentiality agreement prior to participating in the group. Clients with concerns about confidentiality should discuss them prior to beginning group. _____ (initials)

10. ***Professional Boundaries***: Licensed mental health providers are obligated to establish and maintain appropriate professional boundaries (relationships) with present and past clients (and in some cases client's family members). For example providers should not socialize or become friends with clients and should never become sexually involved with a client. _____ (initials)

11. ***Concerns or Complaints*:** We value you as a client and your input about your services. If you have a concern or complaint about your services, your provider will want to know and attempt to resolve any issues together. In the event that you are uncomfortable doing so or cannot resolve your concern with your provider, our executive director, Dr. William Flynn, Assistant Director, Dr. Lori Sipes, or Clinical Director, Stanley Fonder, will be happy to assist you in resolving any concerns. You may also contact:
    a. NH Board of Mental Health Practice, 117 Pleasant Street, Concord, NH 03301, (603) 271-6762;
    b. NH Board of Psychologists, 121 South Fruit Street, Concord, NH 03301
    c. NH Board of Nursing, 21 S. Fruit St., #15, Concord, NH 03301 (603) 271-2323
    d. NH Board of Medicine, 121 S. Fruit Street, Concord, NH 03301-2412 (603) 271-1203.

    _____ (initials)

12. ***Costs of Services*:** Our fees vary by provider's professional discipline/training and you may ask for your provider's fee schedule at any time. Fees for each provider are determined by his/her credentials and are available from the administrative staff. Payment (including copays and deductibles) is due at the time of service. Should you need to cancel an appointment or change an appointment, we require 24 hour notification so that another client may have access to your provider. Your insurance will not cover any portion of the fees for a missed or cancelled appointment. Therefore, there is an $80.00 charge for any appointment that you fail to keep or cancel without providing 24 hours' notice to us. This fee must be paid before we will schedule your next appointment. Sometimes, your insurance carrier will not agree to cover certain services. We will do our best to obtain prior authorization for services but it is your responsibility to pay for services that are provided to you that are not covered by your insurance carrier. _____ (initials)

13. ***Managed Care***: Most managed care/insurance companies limit the number of sessions/ services which will be fully or partially reimbursed. Clients are encouraged to communicate directly with the managed care company about such limitations before starting treatment. Any concerns about the confidentiality of managed care records should also be directed to the managed care company. You should be aware of the potential risks associated with any written diagnosis being submitted to your managed care company. If you do not want this information shared with your managed care company, we can discuss private payments. Occasionally, managed care companies request copies of treatment/progress notes as part of their quality assurance process/to insure that reimbursed services are being provided in agreement with policy declarations (i.e., an internal audit). Because provision of treatment notes on request is part of the client's agreement with their managed care company, it is the policy of MVCA to provide those notes on request. If you do not wish to have your treatment notes made available to a managed care company, please notify us as soon as possible so that private payment arrangements may be made in advance of the service being offered. _____ (initials)

14. ***Additional Services***: In the event that you request or require our provider by subpoena to provide ancillary services relating to our role as your (your child's) provider such as preparing a treatment summary, report writing, deposition, trial preparation and attendance, attendance at a school meeting (e.g., 504 or IEP), travel time, etc. you agree to compensate us in advance at the rate of $200.00 per hour. _____ (initials)

15. ***Testing/Assessment Services***: In general, insurance carriers <u>do not</u> provide coverage for your provider's time that is needed to score and interpret test results. It is your responsibility to pay for that work. Our fee for this service is $175.00 per hour. We require a $500.00 deposit from you before testing begin unless otherwise agreed by contract in advance. _____ (initials)

16. ***Emergency Services*:** In general, our providers work certain days and times and will schedule appointments with you during those times. Should you need to speak with a provider outside of your scheduled appointment, please call our main number (603) 888-4347 and our support staff will get a message to your provider. After hours and weekend calls will be referred to our "on call clinician". In general, we do not provide emergency services and if you are in a life-threatening situation or need emergency care, we ask that you go to the nearest emergency room or call 911. _____(initials)

17. ***Professional Records***: We maintain a record for each client/couple/family. This includes intake/diagnostic interview, diagnosis, treatment plans, billing, consent to treatment, treatment/progress notes and any other written or electronic information we receive about a client. Treatment notes include the date and time of service, and a brief summary of key facts and issues as well as treatment recommendations/interventions. The client (or parent) is entitled to a copy of the records for a fee which covers copying and administrative costs. If you wish to see a copy of your records, we recommend that you review them with your provider so that we can discuss the contents. At your request, we can include your comments/amendments in your record but cannot *change* professional records as this is illegal. _____ (initials)

18. ***Electronic Communications***: Sometimes insurance companies require that we send billing and other information electronically (e.g., by fax or e-mail). Additionally, sometimes a provider will respond to your request for call-back by cell phone. We cannot guarantee the confidentiality of such communications. If you do not consent to electronic communications, please inform your provider immediately, before treatment begins, so that we can determine whether and how to proceed. We do not accept or respond to electronic mail communications about treatment issues. Please call our main number (603) 888-4347 and leave a message for your provider about treatment issues. _____ (initials)

19. ***Coordinated Care*:** Many mental health symptoms are caused or exacerbated by medical concerns. If you have not already done so, we *strongly* encourage you to make an appointment with your primary care physician/your child's pediatrician to discuss symptoms and rule out medical contributing factors within two weeks of your initial appointment with your provider. We also *strongly* encourage you to sign a release of information so that your physician and mental health provider may communicate and coordinate your care as needed. Also, if you are working with multiple MVCA providers, we *strongly* encourage you to sign consent for your providers to share information and coordinate your care. _____ (initials)

20. ***Safety*:** Maintaining safety of self and others is an important component of any mental health treatment. I hereby contract with my clinician to insure my own/my child's and other's safety and will not engage in self- or other-destructive behaviors that would put me/my child or others in imminent danger. I contract to call my therapist if I feel that I am in danger or pose a danger to others. If my therapist is not available, I agree to speak to the on-call clinician. If no direct contact is available, I agree to go to the nearest hospital emergency room. Southern NH Medical Center 603-577-2000 or 603-577-3728; St. Joseph's Hospital 603-882-3000. _____ (initials)

ACKNOWLEDGEMENT AND ACCEPTANCE

My signature below indicates that I have read and understand this document and agree to treatment under its terms.

_____ _____

*Client/Parent/Guardian Signature** *Date*

_____

Printed Name

MERRIMACK VALLEY COUNSELING ASSOCIATION
Northcrest Executive Office Park •39 Simon Street, Unit #2A •Nashua, NH 03060 •(603)888-4347 • Fax (603)577-9157

Payment / Insurance Policy Coverage/ Cancellations

PAYMENT IS DUE AT THE TIME OF SERVICE. THIS INCLUDES CO-PAYMENTS AND DEDUCTIBLES.

Rates: A 45-50 minute session is charged at our standard rate from $150. 00 to $250.00 based on the level of expertise of the provider (examples: Master's Doctorate, ARNP, or MD). A 25 minute session (i.e. a half-hour appointment) is charged at a rate of $75.00, etc. Fees are collected prior to the beginning of each session. For your convenience, we accept cash, check, Visa, MasterCard, or American Express.

Session Policy: The term "one therapy hour" is defined by most HMO, PPO and managed care companies as a 45-50 minute session (not a full hour or 60 minutes). To continue with our standard philosophy and concern for all clients, we will provide additional time for each client above the standard 45-50 minutes should the therapist's schedule allow this flexibility.

Insurance: We are currently mental health providers for several insurance carriers. Please ensure that you have your insurance card with you when you arrive for your session so that we may make a copy of it for your file. Please notify us immediately of any changes in your insurance coverage.

Assignment of Benefits: I authorize MVCA to submit claims on my behalf to my insurance company, Medicare, or other third party payor for my care and authorize disclose of health information to the extent necessary to obtain payment for services. • In consideration of the health care services provided to the patient, I assign and authorize my insurance company, Medicare, or other third party payor to make payments directly to MVCA.
I have been informed that: • I must pay all charges, co-payments, deductibles, and coinsurance not covered by my insurance company, Medicare, or third party payor. • I must pay all charges incurred if I lack insurance coverage and will also contact MVCA to work with them to identify financial options available for me.

Scheduling: Please be aware that scheduling both a psychotherapy and a medication management visit for the same day may create a problem with your insurance company. ***The insurance companies often will not reimburse us for two appointments on the same day***, based on the billing codes the providers use. If you have an appointment with a medication provider and a therapist on the same day (even if one of the appointments is at another practice), please inform our front desk staff and the provider so we can be sure your claims are submitted properly. Otherwise, you may be charged for one of the visits.

Cancellations: YOUR APPOINTMENT TIME IS VALUABLE TO YOU AND TO YOUR CLINICIAN. SHOULD YOU NEED TO CANCEL OR CHANGE YOUR APPOINTMENT, WE REQUIRE 24 HOURS NOTIFICATION SO WE MAY SCHEDULE ANOTHER PATIENT DURING YOUR APPOINTMENT TIME. THERE MAY BE A **$80** CHARGE ASSESSED FOR ANY APPOINTMENT YOU FAIL TO KEEP OR CANCEL WITHOUT PROVIDING 24 HOURS NOTICE TO US. **THIS FEE MUST BE PAID BEFORE WE WILL SCHEDULE YOUR NEXT APPOINTMENT.**YOUR INSURANCE WILL NOT COVER ANY PORTION OF THE FEES FOR A MISSED OR CANCELED APPOINTMENT.

Please sign below to acknowledge your understanding of these policies and accept responsibility to pay for services rendered for same day appointments if they are denied by your insurance company.

READ AND UNDERSTOOD:

Client/Patient Signature* Date

**The parties agree that this agreement may be electronically signed. The parties agree that the electronic signatures appearing on this agreement are the same as handwritten signatures for the purposes of validity, enforceability, and admissibility.*

INFORMED CONSENT CHECKLIST FOR TELEPSYCHOLOGICAL SERVICES

Prior to starting video-conferencing services, we discussed and agreed to the following:

- There are potential benefits and risks of video-conferencing (e.g. limits to patient confidentiality) that differ from in-person sessions.
- Confidentiality still applies for telepsychology services, and nobody will record the session without the permission from the others person(s).
- We agree to use the video-conferencing platform selected for our virtual sessions, and the psychologist will explain how to use it.
- You need to use a webcam or smartphone during the session.
- It is important to be in a quiet, private space that is free of distractions (including cell phone or other devices) during the session.
- It is important to use a secure internet connection rather than public/free Wi-Fi.
- It is important to be on time. If you need to cancel or change your tele-appointment, you must notify the psychologist in advance by phone or email.
- We need a back-up plan (e.g., phone number where you can be reached) to restart the session or to reschedule it, in the event of technical problems.
- We need a safety plan that includes at least one emergency contact and the closest ER to your location, in the event of a crisis situation.
- If you are not an adult, we need the permission of your parent or legal guardian (and their contact information) for you to participate in telepsychology sessions.
- You should confirm with your insurance company that the video sessions will be reimbursed; if they are not reimbursed, you are responsible for full payment.
- As your psychologist, I may determine that due to certain circumstances, telepsychology is no longer appropriate and that we should resume our sessions in-person.

Psychologist Name / Signature: _____ Date: _____

Patient Name: _____

Signature* of Patient/Patient's Legal Representative: _____Date: _____

**The parties agree that this agreement may be electronically signed. The parties agree that the electronic signatures appearing on this agreement are the same as handwritten signatures for the purposes of validity, enforceability, and admissibility.*