The Rested Mind January 2019

*****Please Read and Remember:

1) Medications are not filled by phone or email. **YOU MUST** get them at your appointment time. The holidays are also the same time every year....so please make an appointment before you run out of medications

2) There is a **$100 fee for missed appointment** (see your intake packet). If you do not show up without calling, other patients suffer as we have a waiting list and someone could have had services. Also, since we are fee for service, if you don't come, we do not get paid for the missed time. Please be courteous and call if you cannot come and thoughtful towards your provider

3) Copays are **REQUIRED at the time of service** (per your insurance company's policy). Patient balance will not be allowed to go over $400 dollars at any time. Payments can also be made on our website or calling the office ahead of your appointment. If you have **a deductible plan, we will take a $30 copay at each** visit so the balance is not outrageous when you get the bill. We will refund any copays that are over the amount you own when the insurance sends us your balance.

4) Lost or stolen prescriptions are **NOT the responsibility of your prescriber**, especially if they are controlled substances. We are within our rights not to refill them again. Police reports must be filed if controlled substances are stolen. You **MUST KEEP CONTROL** of your medications. If the provider does send the meds---there will be a fee.

5) Because we are trying to accept as many people as possible (since there is a Mental Health shortage) especially children, your provider may not be able to talk to you if you call. Please remember if they do stop to talk, you are on someone else's time. Also, due to the hours we keep, we may not want to call you on our personal time. Please be considerate and be prepared with all your questions during your scheduled time.

6) Lastly, Per Massachusetts Law...**we do NOT release children's records to anyone without a court order**. Adult records are on a case by case basis. Records are our thoughts on the situation. If they would be harmful for a patient to read, we are allowed (per Mass Law) to give a summary rather than the full chart.

Thanks for your cooperation

The Rested Mind

please sign that you have read this notice _____

—

The Rested Mind

62 Derby Street, Suite 11

Hingham, Ma 02043

To: ALL BEACON HEALTH STRATEGIES/MEDICAID PATIENTS

As Masshealth members, it is not lawful for us to charge you for late cancellations or "No Show" appointments. Since we are a small practice, as of 3/1/2018 we will only allow Masshealth/Medicaid patients ONE missed visit or Late Cancellation without penalty. If a patient misses a subsequent appointment or late cancels a second time, they will be immediately discharged from this practice.

We apologize for any inconvenience this may cause. However, the only other alternative would have been to terminate our Beacon contract completely. We care about our Beacon patients and could not allow this to happen. Unfortunately, our company is too small to have patients No Show or cancel appointments late.

Thank you for your understanding.

Susan Long, Owner

By signing below, you agree to adhere to the above policy change and understand that there will be no exceptions made. This is a company policy. Individual providers are unable to make exceptions on a case by case basis.

PATIENT NAME (PLEASE PRINT)

PATIENT SIGNATURE DATE

The Rested Mind Acknowledgment
of Patient Financial Policy

Printed Patient Name _____ Patients Date of Birth _____

I understand that is my responsibility to be familiar with my insurance plan and what benefits it provides. This includes what referrals, copayments and deductibles are required.

I understand that it is my responsibility to provide The Rested Mind, LLC with accurate and up to date information about my insurance coverage at the time of my visit.

I understand that copayments and deductibles, required by my insurance plan, are my responsibility.

I understand that if I am coming here for a EAP (employee assistance program) visit, that I bring the authorization with the EAP authorization number and approved sessions, so that The Rested Mind, LLC knows how to bill the claim.

I understand that charges not covered by my insurance plan are my responsibility. This includes charges not covered by my insurance plan because I failed to provide the necessary information to The Rested Mind, LLC at the time of my visit that would allow proper adjudication of the insurance claim within the filing deadlines of the insurance plan.

I understand that if I do not call to cancel or reschedule my appointment at least 24 hours in advance, a missed visit fee of $100 will be charged to my account. I understand that missed visit fees are my responsibility, and not an insurance charge. I also understand that repeated missed appointments may result in my inability to make future appointments or result in my termination form the practice.

I authorize my insurance plan to pay benefits directly to The Rested Mind, LLC

I authorize The Rested Mind, LLC to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim.

Signature of Patient/Responsible Party _____ Todays Date _____

THE RESTED MIND
CLIENT INTAKE AND MASTER FORM
THIS PAGE MUST BE FILLED OUT COMPLETELY

PATIENT DATA

Name:_____
Last **First** **Middle Initial**

Address:_____ **Sex** **male** **female**

_____ **Birthdate:**____/____/____

City:_____ **Socail Security#:**_____

State:_____ **Zip:**_____ **Diagnosis:**_____

Home Phone:_____ **Cell Phone:**_____ **Work Phone:**_____

EMAIL Address:_____

LEGAL GUARDIAN:_____ **Phone:**_____

INSURANCE AND BILLING DATA

Insurance Company:_____

Policy#:_____ **Authorization#**_____

Subscriber Name:_____ **Birthdate:**____/____/____

Address (if different from client):_____

Home Phone:_____ **Cell Phone:**_____ **Work Phone:**_____

Relationship to Subscriber:_____

BILLING INFORMATION: I hereby authorize my insurance benefits to be paid directly to The Rested Mind for medical services rendered. I also authorize The Rested Mind to release any information necessary to process this claim. I understand that it is my responsibility to obtain the proper referrals from my health plan and or Doctor. I agree to accept full responsibility for fees owed The Rested Mind, if a referral is not in place at the time of my visit or if for any other reason my health plan does not cover my fees. If I cancel a scheduled session within 24 hours of that appointment, I agree to pay $100.00 fee for the session missed (emergencies exempt.).

CLIENT OR GUARDIAN:

Signature:_____

Printed Name:_____ **Date:**_____

Collateral BillingPatient Request form

The Rested Mind, LLC

This form Is to track and bill for services not covered by health insurance requested outside business hours. Some services must be paid for in advance or due at the time of service. ****Please remember, some services are above and beyond and are not required but are a courtesy. The clinician has the right to refuse (eg. We may choose not to refill medication if inappropriate)**

Phone calls between visits **($30 per unit)**_____
--pt request phone call to discuss something non emergent 1 unit=15 min

School meeting outside the office ($85 per hour) _____
--Therapist travels to meeting to accommodate patients needs

****medications request (weekends/holidays)** if provider chooses to answer ($50 per call) _____
--pt runs of meds due to forgetfulness or looses meds inappropriately

****Medication refill request** ($30 ran out/after hours weekdays) ($30 per call) _____
--pt runs out of meds due to error on their part (forgot appointment, didn't make appointment)

Missed Visits or Late Cancel ($100 per incident) total _____
--first miss excused, billed per incident afterwards

Document preparation (ie SSDI) $30-50 total_____
--extensive paperwork neede and requested by patient that be done after hours

Collateral Contact (PCP, School, other provider, lawyer) ($30 per unit)_____

Patient Name _____ Phone number_____

Email _____

Requested Clinician_____

Notes_____
_____
_____

Total billed_____ Date _____

The Rested Mind, LLC

Fee Schedule as 4/1/19

	NP/MD	Therapist
Initial intake assessment (50 minutes)	$ 250	$180
Medication Management Follow-up (15-20 min)	$ 95	
Medication Management w/therapy (50 minutes)	$150	
Medication Check-Up (15 minute)	$ 95	
Individual therapy / no meds (45 minutes)	$150	
Individual therapy (45 minutes)	**$160**	**$ 135**
Telephone Consultation (15 minimum)	$ 30	$ 30
Couples /Family Therapy (45 minutes)	$	$175
Late cancellation/ No show	$100	$100

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

Above are the self pay/cash rates for our practice. If you have a health insurance that we take, we will bill your insurance directly and **you will be responsible for your co-pay at the time of your visit.** ***You will not be seen without co-payment.***

For other insurance panels (that we do not contract with), you will need to call the number on the back of your insurance card to find out your mental health benefits/coverage. Most insurance companies have allowance for out of network coverage available in order to be seen. You may be subject to a deductible or simply have a higher co-pay. It is usually worth your while to check on what your out of network benefits are.

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

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

Please sign that you have read and agree_____

The Rested Mind, LLC
Mental Health Intake Form

Please complete all information on this form and bring it to the first visit. It may seem long, but most of the questions require only a check, so it will go quickly. You may need to ask family members about the family history. Thank you!

Name_____Date_____

Phone number(s):_____

Date of Birth_____Primary Care Physician_____

Current Therapist/Counselor_____Therapist's Phone_____

What are the problem(s) for which you are seeking help?
1._____
2._____
3._____

Current Symptoms Checklist: (check once for any symptoms present, twice for major symptoms)

( ) Depressed mood
( ) Unable to enjoy activities
( ) Sleep pattern disturbance
( ) Loss of interest
( ) Concentration/forgetfulness
( ) Change in appetite
( ) Excessive guilt
( ) Fatigue
( ) Decreased libido
( ) Racing thoughts
( ) Impulsivity
( ) Increase risky behavior
( ) Increased libido
( ) Decrease need for sleep
( ) Excessive energy
( ) Increased irritability
( ) Crying spells
( ) Excessive worry
( ) Anxiety attacks
( ) Avoidance
( ) Hallucinations
( ) Suspiciousness
( )_____
( )_____

Suicide Risk Assessment

Have you ever had feelings or thoughts that you didn't want to live? ( ) Yes ( ) No.
If YES, please answer the following. If NO, please skip to the next section.
Do you **currently** feel that you don't want to live? ( ) Yes ( ) No
How often do you have these thoughts? _____
When was the last time you had thoughts of dying? _____
Has anything happened recently to make you feel this way? _____
On a scale of 1 to 10, (ten being strongest) how strong is your desire to kill yourself currently? _____
Have you ever thought about how you would kill yourself? _____
Have you planned a time for this? _____
Do you feel hopeless and/or worthless? _____
Have you ever tried to kill or harm yourself before? _____

Do you have access to guns? Yes No
If yes, please explain. _____

Past Medical History:

Current Weight_____Height _____

List ALL current prescription medications and how often you take them: (if none, write none)

Medication Name Total Daily Dosage Estimated Start Date

_____

_____

_____

_____

_____

_____

_____

_____

Allergies to Medications No ( ) Yes( ) what meds?:_____

_____

Current medical problems: _____

_____

Past medical problems, nonpsychiatric hospitalization, or surgeries: _____

_____

Have you ever had an EKG? ( ) Yes ( ) No If yes, when _____ .
Was the EKG ( ) normal ( ) abnormal or ( ) unknown?

For women only: Are you currently pregnant or do you think you might be pregnant? ( ) Yes ( ) No.
Are you planning to get pregnant in the near future? ( ) Yes ( ) No Birth control method ____
How many times have you been pregnant?_____How many live births? _____

Do you have any concerns about your physical health that you would like to discuss with us? ( ) Yes ( ) No
Date and place of last physical exam: _____

Personal and Family Medical History:

	You	Family	Which Family Member?
Thyroid Disease	( )	( )	_____
Anemia	( )	( )	_____
Liver Disease	( )	( )	_____
Chronic Fatigue	( )	( )	_____
Kidney Disease	( )	( )	_____
Diabetes	( )	( )	_____
Asthma/respiratory problems	( )	( )	_____
Stomach or intestinal problems	( )	( )	_____
Cancer (type)	( )	( )	_____
Fibromyalgia	( )	( )	_____
Heart Disease	( )	( )	_____
Epilepsy or seizures	( )	( )	_____
Chronic Pain	( )	( )	_____
Head trauma	( )	( )	_____
Liver problems	( )	( )	
Other	( )	( )	_____
			_____
			_____
			_____

Is there any additional personal or family medical history? ( ) Yes ( ) No If yes, please explain:

_____

_____

Past Psychiatric History:

Outpatient treatment ( ) Yes ( ) No If yes, Please describe when, by whom, and nature of treatment.

Reason Dates Treated By Whom

_____

_____

_____

Psychiatric Hospitalization ( ) Yes ( ) No If yes, describe for what reason, when and where.

Reason Date Hospitalized Where

_____

_____

_____

Your Exercise Level:

Do you exercise regularly? ( ) Yes ( ) No

How many days a week do you get exercise? _____

Family Psychiatric History:

Has anyone in the family been diagnosed with/or treated for:

Bipolar disorder	( ) Yes ( ) No	Schizophrenia	( ) Yes ( ) No
Depression	( ) Yes ( ) No	Post-traumatic stress	( ) Yes ( ) No
Anxiety	( ) Yes ( ) No	Alcohol abuse	( ) Yes ( ) No
Anger	( ) Yes ( ) No	Other substance abuse	( ) Yes ( ) No
Suicide	( ) Yes ( ) No	Violence	( ) Yes ( ) No

If yes, who had each problem? _____

_____

Has any family member been treated with a psychiatric medication? ( ) Yes ( ) No If yes, who was treated, what medications did they take, and how effective was the treatment? _____

_____

Substance Use:

Have you ever been treated for alcohol or drug use or abuse? ( ) Yes ( ) No

If yes, for which substances?_____If yes, where were you treated and when? _____

How many days per week do you drink any alcohol? _____

In the past three months, what is the largest amount of alcoholic drinks you have consumed in one day? _____

Have you ever felt you ought to cut down on your drinking or drug use? ( ) Yes ( ) No

Do you think you may have a problem with alcohol or drug use? ( ) Yes ( ) No

Have you used any street drugs in the past 6 months? ( ) Yes ( ) No

If yes, which ones? _____Have you ever abused prescription medication? ( ) Yes ( ) No

If yes, which ones and for how long? _____

_____

How many caffeinated beverages do you drink a day? Coffee _____ Sodas _____ Tea _____

Tobacco History:
How you ever smoked cigarettes? ( ) Yes ( ) No
Currently? ( ) Yes ( ) No How many packs per day on average? _____ How many years? _____ In the past? ( ) Yes ( ) No How many years did you smoke? _____ When did you quit? _____

Pipe, cigars, or chewing tobacco: Currently? ( ) Yes ( ) No In the past? ( ) Yes ( ) No
What kind?_____How often per day on average?_____How many years? _____

Family Background and Childhood History:
Were you adopted? ( ) Yes ( ) No Where did you grow up? _____
List your siblings and their ages: _____
_____
What was your father's occupation?_____
What was your mother's occupation?_____
Did your parents' divorce? ( ) Yes ( ) No If so, how old were you when they divorced? _____
If your parents divorced, who did you live with?_____
Describe your father and your relationship with him: _____
_____
Describe your mother and your relationship with her:_____
_____
How old were you when you left home?_____
Has anyone in your immediate family died?_____

Trauma History:
Do you have a history of being abused emotionally, sexually, physically or by neglect? ( ) Yes ( ) No.
Please describe when, where and by whom: _____
_____

Educational History:
Highest Grade Completed?_____Where?_____When? _____
Major? _____
What is your highest educational level or degree attained? _____

Occupational History:
Are you currently: ( ) Working ( ) Student ( ) Unemployed ( ) Disabled ( ) Retired
How long in present position? _____
What is/was your occupation? _____
Where do you work? _____

Have you ever served in the military?_____If so, what branch and when? _____
Honorable discharge ( ) Yes ( ) No Other type discharge _____

Relationship History and Current Family:
Are you currently: ( ) Married ( ) Partnered ( ) Divorced ( ) Single ( )Widowed
How long? _____
If not married, are you currently in a relationship? ( ) Yes ( ) No If yes, how long? _____
Are you sexually active? ( ) Yes ( ) No

How would you identify your sexual orientation?
( ) straight/heterosexual ( ) lesbian/gay/homosexual ( ) bisexual ( ) transsexual
( ) unsure/questioning ( ) asexual ( ) other ( ) prefer not to say

What is your spouse or significant other's occupation? _____
Have you had any prior marriages? ( ) Yes ( ) No. If so, how many? _____
Do you have children? ( ) Yes ( ) No _____
If yes, list ages and gender: _____

Legal History:
Have you ever been arrested? _____
Do you have any pending legal problems? _____

Spiritual Life:
Do you belong to a particular religion or spiritual group? ( ) Yes ( ) No
Religious preference? _____

Is there anything else that you would like us to know?

Patient Signature: Date:

Guardian signature____

****we do not release child records to parents without a court order*******

Practice Advisory: Practicing with children and families in Massachusetts where parents may be separated, divorced, or never married

Adopted June 15, 2012

Due to the large number of telephone calls and other inquiries from both licensees and parents in this area of practice, the Board of Registration of Psychologists issues this advisory related to the practice of psychology with children and families in the process of separation-divorce, never married, or post-divorce. Given that this policy deals with issues of confidentiality and testimonial privilege, and potential exceptions thereto, licensees are strongly advised to seek consultation from knowledgeable persons, including legal counsel in an appropriate circumstance:

1. It is very important for a psychologist engaged in treatment of a minor child whose parents are separated or divorced, or who were never married to each other, to understand the custodial rights that each parent has. Under the law, terms like "physical custody" and "legal custody" have specific meanings that are highly relevant to a professional treating a child.

2. The child-client whose parents are divorced or in the process of divorce has his or her own confidentiality rights and evidentiary privilege with respect to his or her relationship with the therapist. **In other words, a psychologist may not divulge the substance of what the child client has discussed either orally or by release of written records just because a parent asks for this information.** ***This information may only be released with a court order or with the signed, informed consent of a mature minor.*** As stated by the Massachusetts Supreme Judicial Court in the 1987 case Adoption of Diane, "[W]here the parent and child may well have conflicting interests, and where the nature of the proceeding itself implies uncertainty concerning the parent's ability to further the child's best interests, it would be anomalous to allow the parent to exercise the privilege on the child's behalf." This case law has been interpreted further to mean that confidential information provided by the child in a psychotherapy environment, including a copy of the child's record, should not be released to either parent or to the court, even with a signed release from one or both parents. Only the court can waive the child's privilege and/or make a determination as to the release of confidential psychotherapy records, and Probate courts can and do appoint special guardian ad litem to decide this question for a child.

3. Child therapists should refrain from initiating therapy with a child without the consent of both parents, unless there are legitimate protective issues relating to the child or other mitigating circumstances. Reaching out to the parent who did not initiate treatment for the child is a best practice that can help the therapist understand all sides of the child's family situation and protect against being perceived as biased or allied with one parent.

4. Sole legal custody is rarely awarded in Massachusetts except in circumstances in which one parent has died, there are protective issues, or the parents were never married. In these cases, the licensee should inquire as to the circumstances of the family before deciding whether to reach out to the non-custodial parent for his/her consent and involvement in the treatment.

5. Psychotherapy and child custody evaluation are two very distinct services with different roles and responsibilities. "Psychologists conducting a child custody evaluation with their current or prior psychotherapy clients and psychologists conducting psychotherapy with their current or prior child

custody examinees are both examples of multiple relationships." (Guidelines for Child Custody Evaluations in Family Law Proceedings, 2010). The same individual should not undertake both roles.

6. A child therapist should not write evaluative reports to lawyers or the court. Factual reports (providing information regarding the existence of the therapeutic relationship) should be provided only in response to a court order and only after legal consultation.

7. A child custody evaluation is a specialized area of practice. In general, such forensic evaluations are conducted by court order and are assigned to specialized practitioners who have been certified in this area and are on the court's list of approved providers, known as "Category E Guardians ad Litem." A comprehensive set of standards apply to evaluative child custody investigations.

8. A therapist for a parent should not write evaluative reports or make custody-visitation recommendations for use in court. Additionally, therapists should never submit evaluative letters or reports regarding the spouse or partner of their patient. (For further information, please refer to the APA specialty guidelines for Child Custody Evaluations http://www.apa.org/practice/guidelines/child-custody.pdf).

9. It is advisable for licensees to communicate to parents prior to initiating treatment with a child, preferably in an informed consent document signed by all parties, that confidential information will not be released to the parent.

10. Working therapeutically with children in separated, divorced, or unmarried families requires a higher level of expertise, training, and consultation than working with children in intact families. It is good practice, whenever one is in doubt about how to proceed, to seek consultation with experts or with an attorney familiar with this work.

This document can be found on the Massachusetts Government site

http://www.mass.gov/ocabr/licensee/dpl-boards/py/regulations/board-policies/policy-bulletin-practicing-with-families.html

The Rested Mind, LLC

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

PLEASE REVIEW IT CAREFULLY

If you have any questions about this notice, please contact the Owner of our office at 781-374-4100, 62 Derby St, Suite 11 Hingham, MA 02043

WHO WILL FOLLOW THIS NOTICE

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

YOUR HEALTH INFORMATION

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

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

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

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

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

c) For Healthcare Operations. We may use and disclose health information about you in order to run the office and make sure that you and our other patients receive quality care. For example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our patients to help us decide what additional services we should offer, how we can become more efficient, or whether certain new treatments are effective.

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

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

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

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

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

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

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

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

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

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

Health Oversight Activities. We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the healthcare system, government programs, and compliance with civil rights laws.

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

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

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

Business Associates. We may disclose your protected health information to a contractor or business associate who needs the information to perform services for The Rested Mind. Our business associates are committed to

preserving the confidentiality of this information.

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

National Security and Intelligence Activities. As authorized or required by law, we may disclose medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities.

Protective Services for the President and Others. As authorized or required by law, we may disclose medical information about you to authorized federal officials so they may conduct special investigations or provide protection to the President, other authorized persons or foreign heads of state.

Organ and Tissue Donation. If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans. If you are or were a member of the armed forces, we may release medical information about you to military command authorities as authorized or required by law. We may also release medical information about foreign military personnel to the appropriate military authority as authorized or required by law.

Family and Friends. We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment, which you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you into the therapy room during treatment or while treatment is discussed.
In situations where you are not capable of giving consent (because you are not present or due to your incapacity or medical emergency), we may, using our professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, we will disclose only
health information relevant to the person's involvement in your care. For example, we may inform the person who accompanied you to the emergency room that you suffered a heart attack and provide updates on your progress and prognosis. We may also use our professional judgment and experience to make reasonable inferences that it is in your best interest to allow another person to act on your behalf to pick up, for example, filled prescriptions, medical supplies, or medically related letters.

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

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

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU
You have the following rights regarding health information we maintain about you:

Right to Inspect and Copy. You have the right to inspect, with a medical professional or attorney, a copy of your health information, such as medical and billing records, that we use to make decisions about your care. You must submit a written request to our Administrator in order to inspect and/or copy in certain limited circumstances. If you are denied access to your health information, you may ask that the denial be reviewed. If such a review is required by law, we will select an independent licensed healthcare professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review. **Children's clinical notes are protected and will not be released (even to parents) without a court order. Adult Mental health records contain sensitive information which may cause mental distress to some patients. In this instance, a summary of treatment may be given rather than the orginal treatment notes or the complete notes can be sent to a secondary mental health provider or attorney, of the patients choosing, for review with the patient.**

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

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

A. We did not create it, unless the person or entity that created the information is no longer available to make the amendment.
B. Is not part of the health information that we keep.
C. Is accurate and complete

Right to an Accounting of Disclosures: You have the right to request an "an accounting of disclosures." This is a list of the disclosures we made of medical information about you for purposes other than treatment, payment and healthcare operations. To obtain this list, you must submit your request in writing to the Administrator. It must state a time period, which may not be longer than six years and may not include dates before May 2, 2010. Your request should indicate in what form you want the list (for example, on paper or electronically). We may NOT charge you for the costs of providing the list the first time. We MAY charge you for the costs of providing the list subsequently. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

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

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

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

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

CHANGES TO THIS NOTICE

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

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact our Clinic Owner at 781-374-4101. You will not be penalized for filing a complaint.

SUMMARY AND SIGNATURE PAGE

I hereby acknowledge that I have been provided a Privacy Notice for The Rested Mind, LLC and understand my rights as a client.

I understand that I have certain rights to restrict the use and disclosure of my Protected Health Information, to obtain a copy of the Notice of Privacy Practices.

Unless I object, my Protected Health Information may be disclosed to assist in notifying a family member, and/or certain other individuals responsible for my care about my location, general condition or my death.

I understand that other uses of my Protected Health Information will be made only as otherwise authorized by law or with my authorization which I may revoke except to the extent information or actions have already been taken.

Signature of client_____ Date_____

_____

Print Name

_____

Signature of Guardian/parent of minor child if applicable

_rev5/2016

TREATMENT CONSENT

_rev5/2016

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

Our hours are Monday through Thursday, 9AM to 8PM, Fridays 9-5pm and Sundays 10am-6pm (closed Saturday). Our services include psychological/psychiatric assessments, problem-focused counseling, referrals to appropriate outside professionals, support and therapy groups, medication management and review and consultations. There is night and weekend crisis beeper coverage for emergencies for existing patients only . We have and neurologist, psychologist, therapists, social workers and nurse practitioners well as supervised trainees in these fields provides these clinical services. We will try to fill any specific preferences you may have for a particular type of counselor (by gender, ethnicity, sexual orientation, etc.), although such requests may delay your first therapy session. Our daytime phone number is 781-374-4100

For emergencies only, which occur outside of routine office hours, our On-call staff can be reached at (617) 228-2805. Please DO NOT CALL THIS for medication refill if you run out. You must come to your appointment to receive your prescriptions. This is for emergencies that cannot wait only. Inappropriate calls will be billed to the patient directly (please see collateral billing form).

Our staff makes every effort to respond to your communications and inquiries as promptly as we can, but in the course of a busy day we each receive numerous messages. If your therapist is not readily available, unless you state that your call is "urgent", a message will be taken for your therapist who will return your call as soon as possible. E-mail is used only for arranging appointments.

Our recommendations to you may include referral to outside programs or therapists when these seem advantageous to your care. Your personal health insurance will be expected to cover part of these treatment costs or you may have to pay for them "out-of-pocket".

Medications may be prescribed by a Psychiatrist or Nurse Practitioner with your agreement after a discussion of the benefits/risks of their use in your circumstances. We are prepared to re-evaluate your need for current or past psychiatric medications and, if appropriate, continue to prescribe these.

The staff practices a Limited Confidentiality. This means that all the information you disclose to us will be treated as private and confidential and will be disclosed only with your permission by signing a Release of Information Form. Confidentiality is broken only in the circumstance where there is a perceived danger to the safety of you or someone else.

We value your comments about our Service at any time. While we encourage you to address such issues directly with your counselor, you may certainly notify the owner of your concerns. After you have reviewed this form please sign below. If you have questions please ask your Counselor. You may have a copy of this form for future reference. We look forward to helping you achieve your life goals.

In order for us to function correctly and provide you the best service possible, it is important that you make every effort to make your scheduled appointment. There are always unforeseen circumstances. However, please call and let your provider know within the appropriate amount of time.

******Appointments cancelled without 24 hour notice are billed at $100 dollars per missed visits. We reserve the right to terminate you as a patient if there are too many missed appointments as it will disrupt our ability to give you the best and safest care. Disrespect of staff or verbal abuse will not be tolerated and will result in termination from the practice.**

*****Please remember that minor children (under age 16), for safety reasons, cannot be left unattended at the office. An adult must accompany and stay with them.**

I have read the above treatment agreement and understand. I was able to ask questions about the policies and procedures listed above and hereby give my consent for treatment:

Patients Signature:_____ Date:

Parent/Guardian Signature_____ Date:

Clinician:_____ Date:

_rev5/2016

PATIENT CONTRACT BETWEEN THE RESTED MIND, LLC AND PATIENTS WHO ARE PRESCRIBED ANY CONTROLLED SUBSTANCES

The purpose of this contract is to protect your access to controlled substances and to protect our ability to prescribe to you.

The long-term use of such substances as opioids (Narcotic pain medicines) benzodiazepine (Xanax, Klonopin), and stimulants (Adderall, Ritalin ect.) barbiturate sedatives (Ambien, Halcion) is controversial because it is not certain whether they help patients over the long term. Patients who are prescribed these drugs have some risk of developing an addictive disorder developing or suffering a relapse of a prior addiction. The extent of this risk is not certain. Also, besides medically obtained substance, club drugs (spice, mushrooms, ecstasy), street drugs (heroin, cocaine, meth) and Alcohol can interact with medications and cause adverse reactions.

Because these drugs can be abused by the patients who receive them, or by others, it is necessary to observe strict rules when they are prescribed over the long term. For this reason, we require each patient receiving long-term treatment with these medications to read and agree to the following policies.

It is agreed by you, the patient, as consideration for, and a condition of, the willingness of the physician/nurse practitioner whose signature appears below to consider prescribing or to continue prescribing controlled substances to treat your condition.

1. All controlled substances must come from a physician/nurse practitioner in this office. My controlled substances will come from the physician/nurse practitioner whose signature appears below, or during his or her absence, by the covering prescriber unless specific authorization is obtained for an exception.

Exception:_____

2. I will inform my physician of any current or past substance abuse, or any current or past substance abuse of any immediate member of my immediate family.

3. I will obtain all controlled substances from the same pharmacy. Should the need arise to change pharmacies; I will inform the all my providers in advance. The pharmacy I am selecting is:

_____ **(pharmacy)**_____**(phone)**

4. I will inform the office of any new medications or medical conditions, and of any adverse effects I experience from any of the medications that I take.

5. I agree that my prescribing physician/Nurse practitioner has permission to discuss all diagnostic and treatment details with dispensing pharmacists or other professionals who provide my health care for purposes of maintaining accountability.

6. I will not allow anyone else to have, use sell, or otherwise have access to these medications.

7. I understand that tampering with a written prescription is a felony and I will not change or tamper with my doctor's written prescription.

8. **I will take my medication as prescribed and I will not exceed the maximum prescribed dose.**

9. I understand that these drugs should not be stopped abruptly, as withdrawal syndromes will likely develop.

10. I will cooperate with unannounced urine or serum toxicology screens as may be requested.

11. I understand that the presence of unauthorized substances may prompt referral for assessment for a substance abuse disorder or discharge from the practice.

12. I understand that these drugs may be hazardous or lethal to a person who is not tolerant to their effects, especially a child, and that I must keep them out of reach of such people for their own safety.

13. I understand that medications may not be replaced if they are lost, damaged, or stolen. If any of these situations arise that cause me to request an early refill of my medication I will be required to complete a statement explaining the circumstances. At that time a determination will be made as to whether I may receive an early refill. **If I request an early refill secondary to lost, damaged or stolen prescriptions twice within a year I will possibly be discharged from the practice.**

14. I understand that a prescription may be given early if the physician or the patient will be out of town when the refill is due. These prescriptions will contain instructions to the pharmacist that the prescriptions(s) may not be filled prior to the appropriate date.

15. **If the responsible legal authorities have questions concerning my treatment, as may occur, for example if I obtained medication at several pharmacies, all confidentiality is waived and these authorities may be given full access to my full records of controlled substances administration.**

16. I understand that failure to adhere to these policies may result in cessation of therapy with controlled substance prescribing by this physician/nurse practitioner or referral for further specialty assessment.

17. *** I will keep my scheduled appointments in order to receive medication renewals. No refills will be given at by phone, fax, at night or on weekends.

18. **I understand that any medical treatment is initially a trial**, and that continued prescription is contingent on whether my physician/nurse practitioner believes that the medication usage benefits me.

19. I have been explained the risks and potential benefits of these therapies, including, but not limited to psychological addiction, physical dependence, withdrawal and over dosage.

20. I affirm that I have full right and power to sign and be bound by this agreement, and that I have read, understand and accepts all of its terms.

21. **I am aware that attempting to obtain a controlled substance under false pretenses is illegal** and I will be terminated from treatment at The Rested Mind, LLC.

Physician/APRN Signature	Patient Signature
Date	Patient Name (printed)

The Rested Mind, LLC 62 Derby Street Suite 11 Hingham MA 02043
781-374-4100 781-749-0809 (fax)

Phone 781-374-4100 Fax# 781-749-0809

AUTHORIZATION FOR USE AND DISCLOSURE OF INFORMATION

Name of Patient_____Date_____/_____/_____

Date of Birth:_____ Phone #_____

I authorize: _____

To release to:_____
Address:_____
Fax # (_____)_____

SPECIFIC DESCRIPTION OF INFORMATION TO BE USED AND DISCLOSED (specify dates for each, unless "entire medical record" is selected) : treatment from_____(date) to_____(date)

_____Hospital Admission Summary
_____Hospital Discharge Summary
_____Entire Medical Record for all dates
_____Progress Notes/Clinic Notes
_____Other (please specify)_____
_____
_____

_____Lab Reports
_____HIV/STD testing
_____medication management history
_____Psychiatric Intake

_____ **Verbal discussion** only – do not release any written records

I AUTHORIZE RELEASE OF ALL ALCOHOL AND/OR DRUG ABUSE RECORDS THAT ARE PART OF THE RECORDS I SPECIFIED ABOVE, UNLESS OTHERWISE INDICATED HERE:

___Do not release records from alcohol or drug abuse treatment programs that are protected under federal law.

PURPOSE OF THE USE AND DISCLOSURE

_____Further Treatment (Date of Appointment_____)
_____Personal Records
_____Education
_____Insurance Application
_____Disability Determination
_____Payment of Insurance Claims
_____Legal
_____Other (specify)_____

I authorize the use and disclosure of my individually identifiable health information as described above, including verbal and written exchanges about the information unless I indicated otherwise. I understand that this authorization is voluntary. I understand that if the person or organization I authorize to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and could be re-disclosed. I understand that my health care and payment for my health care will not be affected if I do not sign this form. I understand that I may revoke this authorization in writing at any time, except to the extent action has already been taken in reliance on it. I understand that this authorization will expire on:_____(specify date or event) or, if no date or event is specified, 12 months from the date of signing. I may pay a fee of $0.25 per page if printing is needed.

A photocopy or fax of this authorization will be treated in the same manner as the original.

_____ _____

Signature of Patient/Guardian/Representative Date

_____

(If not patient, state authority/relationship)