AUTHORIZATION FORM TO OBTAIN/RELEASE PHI

Name of Client:____-_______Date of Birth:_________________________
(Please Print)

South Shore Center for Wellness LTD DBA South Shore Behavioral Health Clinic

SECTION A: USE OR DISCLOSURE OF HEALTH INFORMATION

By signing this Authorization, I authorize the use or disclosure of my individually identifiable health information maintained by: South Shore Center for Wellness LTD 200 Cordwainer Drive, Suite 200 Norwell MA 02061, 109 Rhode Island Road, Lakeville MA 02347

TO OBTAIN INFORMATION FROM ANOTHER ENTITY

From the Provider: ____

Print Name of Provider You are asking for records or speak to

Address: ____

Print Address of Provider

My health information may be disclosed under this Authorization to:

To the Recipient: South Shore Center for Wellness LTD ______________________________

Address: 200 Cordwainer Drive Suite 200 Print Name of Individual to receive information

Norwell MA 02061 Telephone: 781-878-8340

TO RELEASE INFORMATION TO ANOTHER ENTITY

From the Provider: South Shore Center for Wellness LTD

Address: 200 Cordwainer Drive Suite 200, Norwell MA 02061

My health information may be disclosed under this Authorization to:

To the Recipient: ____

Organization to receive the information Print Name of Individual to receive information

Address: ____

Print Address of Recipient Telephone

Health information includes information collected from me or created by the South Shore Center for Wellness LTD. Health information may relate to my past, present or future physical or mental health or condition, the provision of my health care, or payment for my health care services.

Any provider that operates a federally-assisted alcohol or drug abuse program is prohibited from disclosing information about treatment for alcohol or drug abuse without my specific written authorization unless a disclosure is otherwise authorized by federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR, Part 2).

I further understand that under state law South Shore Center for Wellness LTD is prohibited from disclosing information about my HIV status without my specific written authorization. South Shore Center for Wellness LTD is also prohibited under state law from disclosing the results of a genetic test (including the identity of a person being tested) without first obtaining an authorization that constitutes "informed written consent", except when the test results disclosed will be used only as confidential research information for use in epidemiological or clinical research conducted for the purpose of generating scientific knowledge about genes or learning about the genetic basis of disease or for developing pharmaceutical and other treatments of disease.

SECTION B: SCOPE OF USE OR DISCLOSURE

Dates of Treatment or Agency Involvement to which Authorization Pertains: Check One:

Health information that may be used or disclosed through this Authorization is as follows:

❑ **All health information about me, including my clinical records, created by South Shore Center for Wellness LTD.**

This information may include, if applicable:

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

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

• Information regarding the results of a genetic test.

AUTHORIZATION FORM TO OBTAIN/RELEASE PHI

Name of Person Served:______________________________________Date of Birth: ______________________
(Please Print)

❑ All health information about me as described in the preceding checkbox, excluding the following:

____

❑ Specific health information including only:

____

Note: Describe the health information to be excluded or included in a specific and meaningful fashion.

SECTION C: PURPOSE OF THE USE OR DISCLOSURE

The purpose(s) of this Authorization is (are): Check one below:

❑ Specifically, the following purpose(s)____

____

; or ____

❑ The request for information to be used or disclosed has been initiated by the Person Served and/or Parent/Guardian and the Person Served and/or Parent/Guardian does not elect to disclose its purpose.

Note: This box may NOT be checked if the information to be used or disclosed pertains to alcohol or drug abuse identity, diagnosis, prognosis or treatment

SECTION D: EXPIRATION *(Note: If an expiration event is used, the event must relate to the Person Served or the purpose of the use or disclosure.)*

This Authorization expires: ____
(Insert applicable event or date - mm/dd/yy)

SECTION E: OTHER IMPORTANT INFORMATION

1.________ I understand that providers cannot guarantee that the Recipient will not redisclose my health information to a third party. The Recipient may not be subject to federal laws governing privacy of health information. However, if the disclosure consists of treatment information about a Person Served in a federally-assisted alcohol or drug abuse program, the Recipient is prohibited under federal law from making any further disclosure of such information unless further disclosure is expressly permitted by written consent of the Person Served or as otherwise permitted under federal law governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR, Part 2).

2.________ I understand that I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment (or payment, if applicable) from South Shore Center for Wellness LTD, except when I am (I) receiving research-related treatment or (II) receiving health care solely for the purpose of creating information for disclosure to a third party. If either of these exceptions apply, my refusal to sign an authorization will result in my not obtaining treatment (or payment, if applicable) from the Provider.

3.________ 1 understand that I may revoke this Authorization in writing at any time, except that the revocation will not have any effect on any action taken by the Provider in reliance on this Authorization before written notice of revocation is received by the Provider. I further understand that that I must provide any notice of revocation in writing to the Privacy Officer at South Shore Center for Wellness LTD. The address of the Privacy Officer is: Privacy Officer, South Shore Center for Wellness LTD 200 Cordwainer Drive, Suite 200 Norwell MA 02061. 1 further understand that additional restriction on the use or disclosure of my PHI must be requested in writing on a form entitled *Person Served Restriction on Uses and Disclosures of PHI for Treatment, Payment or Operations.*

I have read and understand the term of the Authorization. I have had an opportunity to ask questions about the use or disclosure of my health information.

Person Served/Legal Representative Signature:_________________________________ Date: ______________

Print Full Name of Person Served:____

Relationship of Representative to Person Served: ____

(When Person Served is not competent to give consent, the signature of a parent, guardian, health care agent (proxy) or other representative is required.

PATIENT RESPONSIBILITY FORM (SSBHC)

1. **INDIVIDUAL'S FINANCIAL RESPONSIBILITY**

I understand that I am financially responsible for my health insurance deductible, coinsurance or non-covered service. Co-payments are due at time of service.
If my plan requires a referral, I must obtain it prior to my visit. In the event that my health plan determines a service to be "not payable", I will be responsible for the complete charge and agree to pay the costs of all services provided. If I am uninsured, or change my insurance without notifying the provider I agree to pay for the medical services rendered to me at time of service.

2. **INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS**

I hereby authorize and direct payment of my medical benefits to (South Shore Behavioral Health Clinic) on my behalf for any services furnished to me by the providers.

3. **AUTHORIZATION TO RELEASE RECORDS**

I hereby authorize (South Shore Behavioral Health Clinic) to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services as well as information required for precertification, authorization or referral to other medical provider.

4. **INSURANCE REQUEST FOR PAYMENT**

I request payment of authorized Insurance benefits to (South Shore Behavioral Health Clinic) or on my behalf for any services furnished me by (South Shore Behavioral Health Clinic). I authorize any holder of medical or other information about me to release to the insurance company and its agents any information needed to determine these benefits or benefits for related to services.

____ ____________________
Signature of Patient, Authorized Representative or Responsible Party Date

____ ____________________
Print Name of Patient, Authorized Representative or Responsible Party Relationship to Patient

South Shore Center for Wellness LTD
200 Cordwainer Dr, Ste 200 Norwell MA 02061
Tel: 781-878-8340 Fax: 339-788-9904

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

OUR COMMITMENT TO YOUR PRIVACY
Our practice is dedicated to maintaining the privacy of your personal health information (PHI) as part of providing professional care. We also are required by law to keep your information private. These laws are complicated, but we must give you this important information. This notice is posted in our waiting room. A copy of this document is also available from our front office staff. Please contact our Privacy Officer about any questions or problems you may have.

We will use information about your health which we get from you or from others mainly to provide you with treatment, to arrange payment for our services, and for some other business activities which are called, in the law, health care operations. After you have read this NPP, we will ask you to sign a Consent Form to let us use and share your information. If you do not consent and sign this form, we cannot treat you.

For Treatment
We use your medical information to provide you with psychological treatments or services. These might include individual, family, or group therapy, psychological, educational, or vocational testing, treatment planning, or measuring the benefits of our services.

We may share or disclose your PHI to others who provide treatment to you. We are likely to share your information with your personal physician. If you are being treated by a team, they can share some of your PHI with us so that the services you receive will be able to work together. If you receive treatment in the future from other professionals, we can also share your PHI with them. These are some examples so that you can see how we use and disclose your PHI for treatment.

For Payment
We may use your information to bill you, your insurance, or others so we can be paid for the treatments we provide to you. We may contact your insurance company to check on exactly what your insurance covers. We may have to tell them about your diagnoses, what treatments you have received, and the changed we expect in your conditions. We will need to tell them about when we have met, your progress, and other similar things.

Your Health Care Operations
There are a few ways we may use or disclose your PHI for what are called health care operations. For example, we may use your PHI to see where we can make improvements in the care and services we provide. We may be required to supply some information to some government health agencies so they can study disorders and treatment and make plans for services that are needed. If we do, your name and personal information will be removed from what we send.

Other Uses in Healthcare
Appointment Reminders. We may use and disclose medical information to reschedule or remind you of appointments for treatment or other care. If you want us to call or write to you only at your home or your work or prefer some other way to reach you, we usually can arrange that. Just tell us.

Treatment Alternatives. We may use and disclose your PHI to tell you about or recommend possible treatment or alternatives that may be of help to you.

Other Benefits and Services. We may use and disclose your PHI to tell you about health-related benefits or services that may be of interest to you.

South Shore Center for Wellness LTD
DBA South Shore Behavioral Health Clinic
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Authorized Phone Numbers to Contact Clients

Home: ____________________________ is it ok to leave message _____ yes _______ No

Work: ____________________________ is it ok to leave message _____ yes _______ No

Cell: ____________________________ is it ok to leave message _____ yes _______ No

Spouse: ____________________________ is it ok to leave message _____ yes _______ No

Texting Number : ____________________________ it is ok to text _____ yes _______ No

Email ____________________________ is it ok to leave message _____ yes _______ No

I ______________________ hereby authorize you to call the above numbers checked yes to contact me, leave me a voice message, Email, or contact be by Text.

Client: ________________________________ Date : ___________________

Witness: ______________________________ Date: ___________________

South Shore Behavioral Health Clinic
CLIENT CONSENT FORM

COUNSELING is a confidential process designed to help you address your concerns, come to a greater understanding of yourself, and learn effective personal and interpersonal coping strategies. It involves a relationship between you and a trained therapist who has the desire and willingness to help you accomplish your individual goals. Counseling involves sharing sensitive, personal, and private information that may at times be distressing. During the course of counseling, there may be periods of increased anxiety or confusion. The outcome of counseling is often positive; however, the level of satisfaction for any individual is not predictable. Your therapist is available to support you throughout the counseling process.

CONFIDENTIALITY:

All interactions with South Shore Behavioral Health Clinic, including scheduling of or attendance at appointments, content of your sessions, progress in counseling, and your records are confidential. You may request in writing that the counseling staff release specific information about your counseling to persons you designate.

EXCEPTIONS TO CONFIDENTIALITY:

- The counseling staff works as a team. Your therapist may consult with other counseling staff to provide the best possible care. These consultations are for professional and training purposes.

- If there is evidence of clear and imminent danger of harm to self and/or others, a therapist is legally required to report this information to the authorities responsible for ensuring safety under the "Duty to Warn, Duty to Care Law" MGL Chap 123, sec 36B..

- Massachusetts state law requires that staff of the **South Shore Behavioral Health Clinic** who learn of, or strongly suspect, physical or sexual abuse or neglect of any person under 18 years of age must report this information to child protection services.

- A court order, issued by a judge, may require the **South Shore Behavioral Health Clinic** staff to release information contained in records and/or require a therapist to testify in a court hearing.

We appreciate prompt arrival for appointments. Please notify us, or your therapist if you will be late. Twenty-four hour notice of cancellation allows us to use the time for others.

I have read and discussed the above information with my therapist. I understand the risks and benefits of counseling, the nature and limits of confidentiality, and what is expected of me as a client of the South Shore Behavioral Health Clinic

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______________________________ ______________________________
Signature of Client *Signature of Therapist*

____
Date

South Shore Behavioral Health Clinic
200 Cordwainer Drive, Suite 200 Norwell, MA. 02061
109 Rhode Island Road, Lakeville MA 02347
Tel: 781-878-8340

SSBHC Agency Policy

- If you are seeing another therapist or professional, or another agency that results in non-payment of services you will be responsible for the charges incurred.
- Paperwork requested that is not to another mental health agency, physician, or mental health professional will be at a charge of $1.00 per page, for copies. Letters will be at $75.00 per hour for a therapist and $250.00 per hour for the Psychiatrist or Psychologist. Correspondence to attorneys or certain agencies are not covered by insurance and are subject to the above fees.
- Any paperwork for services not covered by insurance will be subject to $75.00 per hour for a therapist and $250.00 per hour for the Psychiatrist or Psychologist letters, and evaluations.
- Any client that is under the influence of Alcohol or Illegal Drugs that impair their therapy session will result in termination of the session. The session may be rescheduled at the discretion of the therapist and supervisor.
- Dissemination of Mental Health Records are at the discretion of the Supervisor or Medical Director, unless the records are for another Hippa Compliant Mental Health Agency, Licensed therapist, Medical Professional, Psychological Evaluation, or By Subpoena signed by a Judge.
- Cancellation policy requires that a client call with at least 24 hour notice to avoid cancellation fee if without appropriate notice. A fee of $75.00 dollars for a therapist, and $250.00 dollars for the Psychiatrist or Psychologist will be incurred without appropriate notice. Multiple cancellations without notice may result in discontinuation of services with the therapist. Psychiatric Appointments that are repeatedly cancelled or no showed may result in termination of psychiatric services.
- The Client is responsible to notify the Agency Immediately of any changes in insurance, such as new insurance provider, cancellation of policy, Any charges incurred due to cancellation of insurance, changing of policy without notice will be the responsibility of the client or responsible party.

Client: ____ Date: ____________

Parent/ Client or Guardian Signature: ____________________________ Date: ____________

Witness / Therapist: ______________________________________ Date: ____________