Desa & Associates, LLC

Psychiatric Holistic Health

319 Littleton Road, Suite 202, Westford, MA 01886

Phone : (978) 692-0096 Fax : (978) 692-0188

Patient Name: _____ _____ _____DOB_____

Last First Middle

Date of appointment: _____How did you hear about us?_____

EMERGENCY CONTACT INFORMATION: In case of emergency, who should be notified?

Name:_____Relationship:_____Phone:_____

May we leave a message on your cell phone for phone reminders or other matters?

Yes_____ NO_____

email address:_____

Pharmacy Information _____

CURRENT PROVIDERS: By whom were you referred to us?:

_____

Name of Previous Providers:_____

Current Provider Name :_____Phone_____CITY_____

May we contact your therapist for collaboration and disclosure of your mental health information?
YES_____ NO_____

Release of Information to Primary Care : I understand that I may revoke this consent at any time except to the extent action has been taken in reliance upon it and in any event this consent shall expire one year from date of last visit , unless another date is specified. I have read and understand the above information and give my consent.

_____ To release any applicable mental health/substance abuse information to my PCP

_____ I do not give my consent to release any information to my PCP

PCP Name and city/zip code_____

Patient/Guardian Name (Please print clearly) _____DOB_____

Patient/Guardian/ Signature:_____Date_____

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CONSENT TO DISCLOSE MY GENERAL HEALTH INFORMATION and ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize Desa & Associates, LLC to release information necessary to process my insurance claims. I further authorize direct payment of my benefits to Desa & Associates, LLC, for services rendered. I understand that I am financially responsible for any balance not covered by my insurance company, including but not limited to, any deductible or coinsurance designated by my insurer or any services not covered by my insurer. I understand I am responsible to inform Desa & Associates, LLC of all changes in my insurance coverage prior to my next appointment. I also acknowledge it's my full responsibility to call my insurance company to verify coverage for my visits. In the event Desa&Associates, LLC is unable to be paid for those claims for any reason, I acknowledge my responsibility to pay them in full.Desa&Associates, LLC is not responsible to ensure your coverage.

CANCELLATION AND NO SHOW POLICY

It is important that we are notified of appointment cancellations or changes in order to offer that appointment time to others. Please notify the office at least **48hours** in advance.
I acknowledge that I will be charged the **late cancel/no show fee of $100.00** if not cancelled at least 48 hours in advance.

***Please note that the office has a three time no show/cancellation policy.** If a patient is habitually missing appointments without notice or is chronically tardy/frequently canceling visits, we have the right to terminate services due to non-participation in treatment.

In order to better assist you, your mental health information may need to be disclosed to the staff at Desa &Associates, LLC. By signing this form you acknowledge and consent to this disclosure.

Please Print your name clearly: _____DOB_____

Patient Signature/Guardian: _____Date_____

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FINANCIAL POLICY:

Payment for any copays, coinsurance or services not covered by insurance are expected at the time of visit. For your convenience, Desa & Associates, LLC accepts cash and personal checks. Failure to provide payment at time of visit will result in a 10% service charge to cover the cost of billing for that visit. Please note that there will be a **$80.00** charge for any returned checks and cash or money orders will be required thereafter for further visits.

Appointment time is set aside for each individual to discuss treatment, symptoms or other dynamics which may be affecting symptoms/treatment. (*Please refer to Guidelines for Facilitating Psychiatric Treatment and Communication with Your Provider). With the exception of urgent or emergent phone calls.

Telephone fee schedule

Brief Telephone Call/15 min = $75.00 Intermediate Telephone Calls/30min = $150.00 Lengthy Telephone Calls/45min = $225.00 Written Reports= $250.00/hr with a 5 hour retainer. Methods of payment: (Only cash, money order or bank checks accepted)

Court testimony appearances: $300.00/hr with a 6 hour retainer and 2 month notice in advance. Methods of payment: (Only, cash , money order or bank checks accepted)

SAFETY CONTRACT:

Please note that all communications with the Nurse Practitioner at Desa & Associates, LLC are confidential, except in cases where mandated reporting is required as in the case of actual or suspected abuse of a child, elder or disabled individual; situations of danger to self or others; if disclosure is required by statute or court rule; or in the case of supervision received to enhance care provided.

RECEIPT OF NOTICE OF PRIVACY PRACTICES AND PATIENT RIGHTS: My signature below indicates that I acknowledge that a copy of Desa & Associates, LLC's Notice of Privacy Practices and Patient Rights is available in the office for my review

Please Print your name clearly: _____DOB_____

Patient Signature/Guardian: _____Date_____