INTAKE FORM

Desa & Associates, LLC

Psychiatric Holistic Health

319 Littleton Road, Suite 202, Westford, MA 01886

Phone : (978) 692-0096 **Email:** info@healingholistichealth.com

Patient Information

Patient Name: (First)_____ (Middle)_____(Last) _____

Date of Birth: _____

Date of Appointment: _____

How did you hear about us? _____

Emergency Contact Information

Name: _____ Relationship: _____

Phone: _____

May we leave a message on your cell phone for reminders or other matters? Yes[] No [ ]

Insurance Information

Email address: _____

Date of birth: _____

Subscriber's name: _____

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? Yes [ ] No [ ]

Do you agree to telehealth services? Yes[] No [ ]

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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.

[ ] 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 (Print): _____ DOB: _____

Signature: _____ Date: _____

Consent to Disclose and Assignment of Insurance Benefits

I authorize Desa & Associates, LLC to release info for insurance claims and direct payment of benefits.

I am financially responsible for non-covered balances. I will inform of insurance changes.

I acknowledge responsibility for calling insurance to verify coverage.

Patient/Guardian Signature: _____ Date: _____

Cancellation and No Show Policy

Notify 48 hrs in advance for cancellations. Fee of $100 for late cancel/no show.

Three-strike policy for missed appointments.

Consent to disclosure of mental health information to staff.

Print Name: _____ DOB: _____

Signature: _____ Date: _____

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Financial Policy

Payment expected at time of visit.

Credit card, cash, money order, or bank checks accepted.

- *Please note if you have an insurance deductible you will be responsible for 100% of each session.*
- *We are required to have an updated credit / debit card on file*
- *All co-payments, co-insurance, and deductibles will be charged to your credit or debit card after each session*

Limits of Services and Assumption of Risks

Therapy sessions carry both benefits and risks. Therapy sessions can significantly reduce the amount of distress someone is feeling, improve relationships, and/or resolve other specific issues. However, these improvements and any "cures" cannot be guaranteed for any condition due to the many variables that affect these therapy sessions. Experiencing uncomfortable feelings, discussing unpleasant situations and/or aspects of your life are considered risks of therapy sessions.

Limits of Confidentiality

What you discuss during your therapy session is kept confidential. No contents of the therapy sessions, whether verbal or written may be shared with another party without your written consent or the written consent of your legal guardian. The following is a list of exceptions:

- Duty to Warn and Protect: If you disclose a plan or threat to harm yourself or others, the therapist must notify appropriate parties. - Abuse of Children and Vulnerable Adults: Suspected abuse must be reported to appropriate authorities. - Prenatal Exposure to Controlled Substances: Must be reported if disclosed. - Minors/Guardianship: Parents/legal guardians have rights to records of non-emancipated minors. - Insurance Providers: May request information including diagnosis, treatment plans, and progress.

By signing below, I agree to the above assumption of risk and limits of confidentiality and understand their meanings and ramifications.

Client Signature (Client's Parent/Guardian if under 18)

Signature: _____ Date: _____

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Cancellation Policy

If you are unable to attend an appointment, we request that you provide at least 24 hours advanced notice to our office. Since we are unable to use this time for another client, please note that you will be billed for the entire cost of your scheduled appointment if it is not timely cancelled, unless such cancellation is due to illness or an emergency.

For cancellations made with less than 24 hour notice (unless due to illness or an emergency) or a scheduled appointment that is completely missed, you will be mailed a bill directly for the full session fee.

We appreciate your help in keeping the office schedule running timely and efficiently.

Client Signature (Client's Parent/Guardian if under 18)

Signature: _____ Date: _____

Safety Contract

Confidentiality is maintained except where mandated by law (abuse, danger, court order).

Receipt of Notice of Privacy Practices

Acknowledgement of review of Desa & Associates, LLC's Notice of Privacy Practices.

Print Name: _____ DOB: _____

Signature: _____ Date: _____