LiveWell
Therapy Associates, LLC

266 Beacon Street #4R
Boston, MA 02116

INTAKE INFORMATION

Legal/Administrative Name _____ Today's Date_____
Name you'd like us to call you_____ Pronouns _____
Street Address_____
City/State/Zip _____
Email_____ Marital Status _____
Date of Birth_____ Referred By_____
Phone (mobile)_____ Work Phone_____ok to leave a text or voice message? _____
Preferred Contact: Phone ____ email _____

Are you using insurance (BCBS, out of network or Tufts Commercial Plans only)

Insurance

Insurance Co_____ Insurance Phone # _____
Insurance ID#____ _____Group Policy # _____Sex(according to insurance)____
Employer_____
Insurance Company Claims Address and Phone
_____
_____
(if insured is not self)
Insured's Name_____Relationship_____
Insured's Date of Birth_____

Emergency Contact Information

Name _____ Relationship _____
Address _____
Phone_____

Other Information

Physician_____ Phone_____
Physician Address_____
Psychiatrist/Prescriber_____ Phone_____
Date of Last Physical_____
Physical Complaints/Illness/Allergies_____
_____
Medications_____
_____

Date of Intake_____ DX/Code_____
Fees_____

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PRACTICE POLICIES
We do our best to be open and direct about our policies and procedures. We welcome any questions you might have about these policies.

Payments
Payment is due in full at the time of service. We accept insurance and privately paying clients. Acceptable forms of payment are cash, check, or credit cards (including HSA and FSA credit cards).

Payment is due at the time of the visit. You are responsible for making payments in a timely manner.

Fees
Fees are established prior to the beginning of treatment and are payable at the beginning of each session. Fees will be reviewed on an annual basis.

- Intake: individual - $210; couples - $235
- Sessions: individual - $180; couples - $195

Letter writing and other extra administrative work:
- $180/hr billed in 15 minute ($45) increments

Contact Information
Please contact us via email. We prefer not to communicate via text as they are not secure and therefore not HIPPA compliant. Email messages will be responded to more quickly than voicemail messages.

We will return your phone call as promptly as possible, most often within two business days.
We use phone calls and emails only for arranging appointments and for other administrative tasks. We can be of most help in a crisis when we can meet in person. In case of a crisis, We will schedule an appointment with you as soon as possible.

Emergency Coverage
Although we will make every attempt to return phone calls and emails in a timely manner, we are not always immediately available in case of emergency.

All emergencies should be handled by the nearest hospital emergency department if your therapist is not available.

In light of this please call 911 or your local emergency number.

I understand and agree to the above policies
Signed:_____ Date: _____

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This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review carefully.**

We are required by law to maintain the privacy of your health care information, and to provide you with a notice of our privacy practices. While required to abide by the terms of the notice that is currently in effect, we reserve the right to change our privacy practices at any time. If our privacy practices change, we will provide you with a revised notice at your next visit following the change.

Your Rights
You have the right to confidentiality of personal health care information obtained by your therapist from you, and/or created by us in connection with treatment provided to you.

Subject to certain restrictions and exceptions,

- You have the right by law to request restrictions on the use and disclosure of your information *except in emergency circumstance*s. We are not required to agree to the requested restriction and will not unless we agree that a compelling reason exists to do so.
- You have the right by law to review and obtain copies of your personal health information from Livewell. If you would like us to use another address or telephone number to contact you, you must request so in writing.
- You have the right by law to receive an accounting of disclosures made by this office of your health care information other than disclosures regarding treatment, payment or health care operations that you have authorized.

Limitations On Your Rights
Generally, your therapist cannot tell anyone about you or the things you say during your treatment sessions unless you freely authorize the disclosure, in writing. However, by law:

- Your therapist is mandated to report any suspicion of abuse or neglect of another.
- Your therapist may disclose confidential information if someone's life or safety is in danger.
- Your health information may be used to develop a diagnosis and treatment plan, or to coordinate care and referrals with your healthcare provider.
- Your therapist may use your information for treatment, payment, and health care operations. For example, portions of your health information may be submitted to your insurance carrier or third-party payor to secure payment on your behalf. You have the right to pay for treatment yourself rather than allow the release of such information to the insurance company.
- Your therapist may use your health information in connection with other internal health care operations such as quality assurance, evaluation of services, or record audit activities.
- Your health information may be used so your therapist can contact you with appointment reminders.

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CANCELLATION AND PAYMENT POLICY

Appointment times are reserved for you in advance. A minimum of 1 business day (24 hours) notice for cancellations is required. Monday appointments need to be canceled by 5 pm the preceding Friday. Appointments that are missed without 24 hours notice will be charged at a rate of $150. This enables your therapist to serve you and all of their other clients who may need to reschedule appointments.

The charge for a scheduled appointment not canceled 1 business day (24 hours) before the appointment is **$150**. We are not able to bill insurance for cancellations, so you, the client, are financially responsible for any sessions canceled less than 24 hours in advance..
Initial here to indicate that you understand this cancellation policy: _____

If I have to cancel, your therapist will make every effort to reschedule if you wish not to miss an appointment. If you are able to be rescheduled the same week, there will not be a cancellation charge.

This policy applies to an appointment you did not attend because you have decided not to continue counseling, you forgot an appointment, an appointment conflicts with another one you have made, if you become ill, if the weather becomes a problem, or any other reason.

Charges for late cancellations or missed appointments are not billable to your insurance company. Fees for sessions, including copays, deductibles, co-insurance, and self-pay fees, are due at the time of the session.

The credit card you are providing will automatically be charged the full fee for late cancellations, missed appointments or unpaid fees unless we have made other arrangements ($180 for individual and $195 for couples).
Initial here to indicate you understand this charge policy: _____

It is essential to keep an active, up to date credit card on file. I ask that you be mindful of credit cards being updated and reissued (often because of bank security issues, expiration and closing or inactivating the credit card account) and update this form as necessary. Due to federal regulations the card on file cannot be to be your tax deferred acct., i.e., Health Savings Account (HSA), Flexible Spending Account (FSA) or Health Reimbursement Arrangements (HRA).
Please provide your credit card information below (credit or debit cards only).

Name on Card: _____
Credit Card: ☐Master Card ☐Visa ☐Discover ☐American Express
Number: _____
Expiration Date: _____ Security Code: _____ Billing Zip Code: _____

I hereby agree to this cancellation and payment policy.

Signed: _____ Date: _____

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I may be required to share information with third parties to comply with:

- Public health statutes and rules;
- Health oversight activities by government agencies (for example, licensure); or
- A court order, government subpoena, or other lawful process.
- Some business associates who perform services on my behalf may also have access to your personal health information. These business associates are required by law to maintain the confidentiality of your health care information.

I understand and agree to the above policies.
Signed: _____ Date: _____