PLEASE READ THE FOLLOWING CAREFULLY BEFORE SIGNING

I consent to evaluation and, if indicated and offered, treatment.

I authorize the release of any medical or other information necessary to process claims submitted to my insurance company or other third-party payer. I also authorize payment of medical benefits directly to Labyrinth Psychological Services, P.C.

If my treatment involves more than one clinician, I authorize my clinicians to communicate and exchange information by letter, telephone, secure electronic mail, and facsimile about my diagnosis and treatment. Information discussed may include, but is not limited to, psychiatric and psychological evaluations including alcohol and drug use, medical history and laboratory studies, prescribed medications, and results of psychological testing. I understand that this is done to facilitate my care.

I also understand that if my insurance company or other third-party payer manages my mental health benefits, written evaluations and treatment plans containing personal information will be given to case managers of these organizations in accordance with federal HIPAA regulations and Massachusetts Law. Letters and reports, telephone contact, facsimile transmissions, and other secure electronic communication may also be required, and I consent to this communication. I understand that all persons with access to any of this information are required by law to treat the information as strictly confidential. This authorization begins at the date signed below.

☐ I authorize my primary care provider to communicate and exchange information by letter, telephone, secure electronic mail, and facsimile. These contacts will be to discuss my medical and psychiatric diagnoses, treatment recommendations and plans, medical and laboratory tests, and medications.

_____ _____

NAME OF PRIMARY CARE PHYSICIAN **PATIENT'S SIGNATURE**

☐ I specifically authorize the use of facsimile technology and secure electronic mail to transmit medical, clinical, and administrative information relating to my care and treatment. This authorization is in effect as long as these communications are done in keeping with the policies and procedures of Labyrinth Psychological Services, HIPAA regulations, and the laws of the Commonwealth of Massachusetts.

_____

PATIENT'S SIGNATURE

☐ I have received a copy of "Patient Contract for Outpatient Treatment", which details the patient/provider policies and procedures of Labyrinth Psychological Services. I have read the "Please Note the Following" section on the first page of the contract, and specifically agree to the billing policy for "broken appointments".

_____

PATIENT'S SIGNATURE

I understand that, by law, I need not consent to release of this information. However, I choose to do so voluntarily for the purpose of facilitating my evaluation, and if indicated, treatment. I understand that I may revoke this consent at any time except to the extent that action based on it has already begun. Revocation of this consent requires written notification. I understand that my records are protected under the Federal Regulation 42 CFR, Confidentiality of Alcohol and Drug Abuse, under HIPAA regulations, and under the General Laws of Massachusetts and cannot be disclosed without my written consent except as otherwise specifically provided by law. All information sent will be held strictly confidential. Having read and understood this form, I release the above listed persons or agencies from any liability arising from this release of information provided the information is released in accordance with applicable law.

_____

NAME OF PATIENT (PLEASE PRINT)

_____ _____

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN **DATE**

Revised 02/11/2016

PATIENT INFORMATION and INFORMED CONSENT FOR TREATMENT

Today's Date: _____ / _____ / _____

Name: _____ **DOB**: ____-____-____ **SS#**: _____-_____-_____

Address:_____ **Sex**: MALE FEMALE
Street City or Town Zip Code

Home Phone: (_____) _____-_____ **Mobile Phone**: (_____) _____-_____

Work Status: EMPLOYED | FULL-TIME STUDENT | PART-TIME STUDENT

E-mail Address: _____ Can you be contacted confidentially by e-mail? ☐ YES ☐ NO

Patient's Work Phone: (_____) _____-_____ **Marital Status**: SINGLE | MARRIED | DIVORCED | WIDOWED

If patient is less than 18 years old, name of parents or guardians: _____

_____ **Parent or Guardian Daytime Phone**: (_____) _____-_____

Have you been in treatment before? ☐NO ☐ YES If yes, when and with whom?

_____

Do you have Health Insurance? ☐NO ☐Medicare ☐Private Insurance **Name**:_____

Policy number: _____ **Group number**: _____

Are you the subscriber? ☐YES ☐NO. If no, name of the subscriber:

_____

Subscriber is: SELF | SPOUSE | PARENT | OTHER **Subscriber's DOB**: ____-____-_____ **Sex**: MALE FEMALE

Subscriber's SS#: _____-_____-_____ **Address:** _____

Phone: (_____) _____-_____ **Subscriber's Employer:** _____

Are you covered by a second insurance? ☐ NO ☐YES. If yes, name of insurance:_____

2nd Subscriber's name: _____ **DOB**: ____-____-_____ **Sex**: MALE FEMALE

2nd insurance number: _____ Employer: _____

Is your treatment covered by Worker's Compensation? ☐ NO ☐YES. **Are you disabled?** ☐NO ☐YES

Do you have a primary care physician? ☐NO ☐YES

Name of physician: _____

Address:_____

Phone: (_____) _____-_____ Fax: (_____) _____-_____

PLEASE TURN TO THE OTHER SIDE FOR INFORMED CONSENT INFORMATION

Revised 02/11/2016