Harmony Psychiatric Services
22 Stiles Rd – Ste 104
Salem, NH 03079
Tel: (603) 475-8322
Email: harmony@harmonypsychiatric.com

HARMONY NEW PATIENT FORM

PATIENT INFORMATION

Date: _____ Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Birth Sex: (circle) *Male* / *Female* / *Other* / *Decline to Answer* Preferred Pronouns: _____

Gender Identity: (circle) *Male* / *Female* / *Trans Male* / *Trans Female* / *Non-Binary* / *Other* / *Decline to Answer*

INSURANCE INFORMATION (We are currently able to accept Aetna, BCBS, Cigna, Harvard Pilgrim, Tufts, United)

Primary Insurance:

Policy Holder's Name: _____ Policy Holder's Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Insurance Company: _____

Insurance Plan: _____ Insurance ID #: _____

Secondary Insurance (if applicable):

Policy Holder's Name: _____ Policy Holder's Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Insurance Company: _____

Insurance Plan: _____ Insurance ID #: _____

Policy for minor patients: If the patient is a minor, we need all parents/guardians to agree to treatment. By signing this form, you are informing us that all legal parents/guardians agree to medication and therapy for the minor. Please include name, phone number, and email of each parent/guardian below.

Parent/Guardian One: _____ Home Phone: _____

Cell Phone: _____ Email: _____

Signature: _____ Date: _____

Parent/Guardian Two: _____ Home Phone: _____

Cell Phone: _____ Email: _____

Signature: _____ Date: _____

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COPAY, SELF PAY, DEDUCTIBLE INFORMATION

Payment/Insurance Filing: Payment of fees, including any required co-pays, is expected at the time of each appointment. We request that payment be made before your session begins. If you are using insurance benefits, Cedar Whole Life Counseling will file insurance claims for you, and we will honor any contractual requirements. If you are not using a Managed Care/PPO/HMO insurance plan and wish to file you own claim, we expect full payment at the time of service, and we will provide you with a statement for services rendered. Monthly payment arrangements are available if needed for clients who have established a payment record for three months.

At Harmony Psychiatric Services, we require keeping your credit card or debit card on file as a convenient method of payment for the portion of services that your insurance does not cover, but for which you are liable. These services include co-payments, deductibles, and missed appointments. Your card information is kept confidential and secure. I, the undersigned, authorize and request Harmony Psychiatric Services to charge my credit or debit card, indicated above, for all balances due to services rendered that my insurance company identifies as my financial responsibility. This authorization will remain in effect until I cancel this authorization. To cancel, the account must be in good standing.

I authorize Harmony Psychiatric Services to charge the portion of my bill that is my financial responsibility to the following credit or debit card:

Card Type: (circle) *VISA / MASTERCARD / AMERICAN EXPRESS*

Card Holder's Name: _____

Card Number: _____ Expiration Date: _____

CVV: _____ Billing Zip Code: _____

Card Holder's Signature: _____ Date: _____

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HARMONY PSYCHIATRIC POLICIES

Please initial each policy, and sign and date at the bottom.

Cancellation Policy: I request that clients cancel at least 24 hours before their scheduled appointment. There is a cancellation fee of $100 for all appointments missed without 24-hour notice. *Initials* _____

Communication Policy: There are several ways to get in touch with us. We do ask that you do not contact us through your provider's email. Things get missed or lost that way. Harmony is also trying to help our providers stay focused on their families when they are not with patients in order to practice good self-care. The provider's email is only to send links for telehealth. We ask that you do one of the following:

Email us at harmony@harmonypsychiatric.com

Website contact form at http://www.harmonypsychiatric.com/contact-us.html

Call the office at **1-603-475-8322**

Due to the small size of the practice, please allow 48 - 72 hours for a response. Although we do try to get back much sooner, we ask to keep this timeframe in mind. Also, as a reminder, we do not have on-call services and are not available 24/7. If you have a medical or mental health emergency, we urge you to call 911.

Initials _____

Emergencies: You may encounter a personal emergency that will require prompt attention. In this event, please contact our office regarding the nature and urgency of the circumstances. We will make every attempt to re/schedule you as soon as possible or to offer other options. Because clients may be scheduled back-to-back, it is not always possible to return a call immediately. However, we will make every effort to respond to your emergency in a timely manner. If your emergency arises after hours or on a weekend, and you are experiencing a life-threatening emergency, call 911 or have someone take you to the nearest emergency room for help. **THERE ARE NO ON-CALL SERVICES.** *Initials* _____

Medication Refill Policy: All medication refill requests must be made **7 - 10 days PRIOR** to being out of medication. Please do this ONLY on the website. *Initials* _____

Discharge Policy: We reserve the right to discharge a patient at any time. It does not happen often, but it is a possibility that certain situations require another type of care, a referral, or some other reason. We will always communicate that effectively to you. *Initials* _____

HIPAA: I understand my rights under HIPAA and was offered a form to confirm. *Initials* _____

Patient or Parent/Guardian Name (print): _____

Patient or Parent/Guardian Signature: _____

Date: _____

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HIPAA NOTIFICATION

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

Harmony Psychiatric follows all ethical standards prescribed by state and federal law. We are required by practice guidelines and standards of care to keep records of your counseling. These records are confidential with the exceptions noted below and in the Notice of Privacy Practices provided to you.

Discussions between a Therapist and a client are confidential. No information will be released without the client's written consent unless mandated by law. Possible exceptions to confidentiality include but are not limited to the following situations: child abuse; abuse of the elderly or disabled; abuse of patients in mental health facilities; sexual exploitation; AIDS/HIV infection and possible transmission; criminal prosecutions; child custody cases; suits in which the mental health of a party is in issue; situations where the Therapist has a duty to disclose, or where, in the Therapist's judgment, it is necessary to warn or disclose; fee disputes between the Therapist and the client; a negligence suit brought by the client against the Therapist; or the filing of a complaint with the licensing or certifying board. If you have any questions regarding confidentiality, you should bring them to the attention of the Therapist when you and the Therapist discuss this matter further. By signing this Information and Consent Form, you are giving consent to the undersigned Therapist to share confidential information with all persons mandated by law and with the agency that referred you and the insurance carrier responsible for providing your mental health care services and payment for those services, and you are also releasing and holding harmless the undersigned Therapist from any departure from your right of confidentiality that may result.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments?

- ☐ Yes
- ☐ No

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May we leave a message on your home phone or on your cell phone?

- ☐ Yes – either phone
- ☐ Yes – home phone only
- ☐ Yes – cell phone only
- ☐ No

May we discuss your medical condition with any member of your family?

- ☐ Yes
- ☐ No

Please list the names of any family members you give consent to:

_____

_____

Duty to Warn / Duty to Protect: If my Therapist believes that I (or my child if child is the client) am in any physical or emotional danger to myself or another human being, I herby specifically give consent to my Therapist to contact any person who is in a position to prevent harm to me or another, including, but not limited to, the person in danger. I also give consent to my Therapist to contact the following person(s) in addition to any medical or law enforcement personnel deemed appropriate:

Name: Telephone Number:

_____ _____

_____ _____

Incapacity or Death: I understand that, in the event of the death or incapacitation of the Therapist, it will be necessary to assign my case to another Therapist, and for that Therapist to have possession of my treatment records. By my Signature on this form, I herby consent to another licensed mental health professional, selected by the practice, to take possession of my records and provide me copies at my request, and/or to deliver those records to another therapist of my choosing. *Initials* _____

Electronic Service Delivery: Harmony Psychiatric is currently delivering all services electronically, including the use of Zoom for telehealth appointments, email, the contact form on our website, and the medication refill request form on our website. *Initials* _____

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Consent to Treatment: By signing this Client Information and Consent Form as the Client or Guardian of said Client, I acknowledge that I have read, understand, and agree to the terms and conditions contained in this form. I have been given appropriate opportunity to address any questions or request clarification for anything that is unclear to me. I am voluntarily agreeing to receiving mental health assessment, treatment and services for me (or my child if said child is the client), and I understand that I may stop such treatment or services at any time. NOTE: If you are consenting to treatment of a minor child, if a court order has been...

Patient Name (print): _____

Patient Signature: _____ Date: _____

Parent/Guardian One (print): _____

Parent/Guardian One Signature: _____ Date: _____

Parent/Guardian Two (print): _____

Parent/Guardian Two Signature: _____ Date: _____