Starr Psychiatric Center

Date: _____

Patient Information

Name: _____ Phone #'s: Home: _____

Address: _____ Cell: _____

City: _____ Work: _____

Date of Birth: _____ SS#: _____

Height: _____ Weight: _____ Blood Pressure: _____

Email: _____

Which phone would you like us to contact you at? _____

Is it Ok for messages at this number, please circle: Yes or No

If no – where can we leave a message for you? _____

We have the ability to send appointment reminders via automated call, email or text. How would you like us to contact you? **PLEASE CHOOSE ONLY ONE**

Call #: _____ Email: _____

Text #: _____

Please circle your race: Caucasian African American Asian Alaskan Native

Native Hawaiian Pacific Islander American Indian

Please circle: Hispanic or Non-Hispanic

Please circle your preferred language: English Spanish Portuguese Chinese German

Italian Japanese Korean Russian Arabic French

Please circle your education level: High School Graduate Some college or Associate Degree

Bachelor's Degree & higher Less than a High School diploma

Please circle your cigarette smoking status: Non-smoker Smoker Former smoker

Occasional smoker Every day smoker

Name of Insurance Company: _____

Subscriber ID#: _____ Group #:_____

Additional Health Insurance: _____

Nearest Relative: _____ Telephone #: _____

Address: _____

Referred by: _____

Name & address of person responsible for the bill: _____

_____

Patients will be charged the full fee for missed appointments or cancelled appointments for Starr Psychiatric Center unless other arrangements are made with the doctor. An interest charge of 1 ½ % a month will be added to any unpaid balance after 30 days unless special arrangements are made with the doctor. Patient acknowledges they will be charged additional fees for miscellaneous charges including but not limited to: forms, letters, testing etc.

Person Responsible for the bill Signature: _____

Please print name: _____ Date: _____

Starr Psychiatric Center
529 Pearl Street
Brockton, MA 02301

ASSIGNMENT OF BENEFITS – INSURANCE FORM

_____ _____

Patient Name D.O.B.

In consideration of the care provided to me or the above patient, I, as the responsible party, assign Starr Psychiatric Center or to the provider rendering care, all medical insurance benefits applicable to my treatment at this visit and future visits. I furthermore instruct the insurance company or companies or third party payment programs to make payment directly to Starr Psychiatric Center or the provider directly.

I understand that I am ultimately financially responsible for all charges incurred for the care of the above patient if my insurance company does not pay.

_____ _____

Signature of Responsible Party Date

_____

Relationship to above

RELEASE OF INFORMATION TO INSURANCE CARRIERS

I authorize Starr Psychiatric Center to furnish my insurance carrier(s), upon request, with whatever information it deems necessary concerning said care and treatment of (patient's name): _____, including photocopies of the medical record, which may contain information regarding Alcohol and Drug Abuse Treatment or other personal information.

This consent will stand as current unless I otherwise notify the Starr Psychiatric Center in writing or 1 (one) year after last visit.

_____ _____

Signature of Responsible Party Date

_____

Relationship to above

Patient's Acknowledgement of Receipt of
Notice of Privacy Practices

Patient Name:_____ Birth date:_____

Maiden or other name (if applicable):_____

I acknowledge that I have received a copy of the Notice of Privacy Practices of the Starr Psychiatric Center, effective April 14, 2003. I understand that the Starr Psychiatric Center has a right to change this notice at any time. If such a change occurs, I will be provided with a new copy of the notice in a timely fashion.

Signature (patient or authorized representative):_____

Date:_____

Relationship/authority:_____

(If signed by authorized representative)

Patient Name : Date:

Are you allergic to any medications? NO ☐ YES ☐ Please list:

Past Medical History

	Yes	No		Yes	No
Diabetes	☐	☐	Heart Palpitations	☐	☐
Chest Pain/Angina	☐	☐	Arthritis	☐	☐
High Blood Pressure	☐	☐	Heart Surgery	☐	☐
Heart Disease	☐	☐	Blood Clots	☐	☐
Heart Attack	☐	☐	Peripheral Vascular Disease	☐	☐
High Cholesterol	☐	☐	Tuberculosis	☐	☐
Pacemaker	☐	☐	Depression	☐	☐
Headaches	☐	☐	Congestive Heart Failure	☐	☐
Kidney Stones	☐	☐	Thyroid Disease	☐	☐
Kidney Disease	☐	☐	Other (please list below)		
Cancer	☐	☐			
Osteoporosis	☐	☐			
Asthma/COPD	☐	☐			
Stroke/CVA/TIA	☐	☐			
Seizures	☐	☐			
HIV/AIDS	☐	☐			
Hepatitis	☐	☐			
Stomach Ulcer	☐	☐			
Liver Disease	☐	☐			

Current Medications

ROS		Please check all **CURRENT** positive findings
Constitutional		Weight loss ☐ Fevers ☐ Chills ☐ Poor appetite ☐ Fatigue ☐ Weight gain ☐ Insomnia ☐ Night sweats ☐
Eyes		Blurry vision ☐ Eye pain ☐ Eye discharge ☐ Eye redness ☐ Decrease in vision ☐ Dry eyes ☐ Double vision ☐
ENT		Sore throat ☐ Hoarseness ☐ Ear pain ☐ Hearing loss ☐ Ear discharge ☐ Nose bleeds ☐ Tinnitus ☐ Sinus problems ☐
Cardiovascular		Chest pain ☐ Palpitations ☐ Rapid heart rate ☐ Heart murmur ☐ Poor circulation ☐ Swelling in the legs or feet ☐
Respiratory		Shortness of breath ☐ Chronic cough ☐ Coughing up blood ☐ History of Tuberculosis ☐ Excess sputum production ☐
Gastrointestinal		Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation ☐ Blood in the stool ☐ Frequent heartburn ☐ Trouble swallowing ☐
Genitourinary		Increased urinary frequency ☐ Blood in the urine ☐ Incontinence ☐ Painful urination ☐ Urinary retention ☐ Frequent UTIs ☐
Skin		Rash ☐ Hives ☐ Hair loss ☐ Skin sores or ulcers ☐ Itching ☐ Skin thickening ☐ Nail changes ☐ Mole changes ☐
Musculoskeletal		Joint pain ☐ Muscle aches ☐ Frequent leg cramps ☐ Muscle weakness ☐ Bone pain ☐ Joint swelling ☐ Back pain
Psychiatric		Anxiety ☐ Depression ☐ Alcohol or drug dependence ☐ Suicidal thoughts ☐ Panic attacks ☐ Use of anti-depressants ☐
Endocrine		Goiter ☐ Heat intolerance ☐ Cold intolerance ☐ Increased thirst ☐ Change in skin pigment ☐ Excess sweating ☐
Neurological		Seizures ☐ Tremors ☐ Migraines ☐ Numbness ☐ Dizziness/Vertigo ☐ Loss of balance ☐ Slurred speech ☐ Stroke ☐
Hem/Lymphatic		Low blood count ☐ Easy bruising ☐ Swollen lymph nodes ☐ Transfusions ☐ Prolonged bleeding ☐ Blood clots ☐
Allergic/Immune		Allergic reactions ☐ Hay fever ☐ Frequent infections ☐ Hepatitis ☐ HIV positive ☐ Positive tuberculin skin test (PPD) ☐

Social History: Marital Status_____ Occupation (or most recent job held) _____

Non-Smoker (never smoked) Ex-Smoker Current Smoker How many packs per day? _____

Alcohol consumption: Never Occasional Frequent

Family History: (Please list any known medical problems)

Father: _____ Mother: _____

Siblings: _____

Your Children: _____

Additional Information: Use this space to provide any additional information which may be important to your health care.

_____ _____

Signature of Reviewing Physician Date Signature of Patient Date

Starr Psychiatric Center, Inc.
529 Pearl Street, Brockton, MA 02301
(508) 580-2211

PATIENT TELEHEALTH CONSENT FORM

I. INTRODUCTION

I understand that my continued medical care could be facilitated by using telehealth for my therapy. My provider has informed me of the benefits and risks of using telehealth as a method of health care delivery. As a result of this discussion, I have decided to use telehealth for my care. I have signed this form electronically at my first telehealth appointment after having been given an opportunity for my provider to answer any questions. I understand that a signed copy of this form will be placed in my medical record.

II. BENEFITS

- I understand that my provider believes that telehealth will benefit my care.
- I understand that under certain conditions, such as during an epidemic when public health authorities have recommended self-quarantine or social distancing, it may be safer to receive care at home rather than travel to a doctor's office or other clinical setting.
- I understand that telehealth doesn't replace the potential need for in-person appointments between me and my provider. This determination will be made by my provider.
- My provider has given me instructions on the proper use of telehealth and has answered all my questions to my satisfaction.

III. FEDERAL and STATE LAW

Federal law requires that health care providers protect the privacy and security of my personal health information.

- I understand that my provider has undertaken reasonable efforts to provide a system designed to protect the security and privacy of my personal health information using HIPAA-compliant protocols, including the selection of technology partners who are also governed by Federal and state regulatory requirements regarding the protection and privacy of patient health information, at the provider's location.
- I understand that my provider must inform me of the location of provider rendering services and obtain the location of the patient receiving services.
- I understand that federal and state law is changing rapidly in response to the COVID-19 epidemic and that this provider will use technology that is allowable by state and federal law.

IV. RISKS

- I understand that my telehealth sessions help my provider care for me but may be different from in-person, face-to-face treatment. If the standard of care cannot be maintained using this method of healthcare delivery, my provider will notify me that this is the case and advise me to seek in person care.
- I understand that there are risks and consequences from telehealth, including, but not limited to disruptions or distortions of video and audio transmission due to technical difficulties. Deficiencies or

failures of the equipment could result in delay in medical evaluation or treatment and could affect the treatment session.

- There is potential for unauthorized interruptions by third parties.
- I understand that my insurance carrier may refuse to pay or reimburse for telemedicine, in which case I will be responsible for payment.

V. CONSENT

- I understand that I may withdraw my consent to continue treatment by telehealth at any time however, any treatment received from my provider prior to receipt of my withdrawal of consent will not be affected.
- My withdrawal of consent and termination of telemedicine-based treatment will not affect my current or future treatment by my provider.
- I understand that I am responsible for providing equipment and internet or telephone access for telehealth.
- I understand that I am responsible for arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my telehealth appointments
- No third parties shall be present or have access to a telemedicine session during its occurrence without my and my provider's written permission.
- I understand that it will be my responsibility to determine whether my insurance carrier will provide coverage for any treatment I receive, and I will be responsible for full payment in the event that the insurer denies coverage.
- I have had the opportunity to ask questions about the use of telemedicine including the risks and benefits and my provider has answered all of my questions to my satisfaction.

I have read and understand the information provided above regarding my treatment by telehealth and have been given the opportunity to ask questions of my provider.

SIGNATURE OF PATIENT OR GUARDIAN DATE

PRINT PATIENT NAME

SIGNATURE OF PROVIDER DATE

Starr Psychiatric Center
529 Pearl Street
Brockton, MA 02301

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED, DISCLOSED AND SAFEGUARDED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Who is Subject to This Notice

All patients of Starr Psychiatric Center, located at 529 Pearl Street, Brockton, MA 02301

II. Our Responsibility

The confidentiality of your personal health information is very important to us. Your health information includes records that we create and obtain when we provide you care, such as a record of your symptoms, examination and test results, diagnosis, treatments and referrals for further care. It also includes bills, insurance claims, or other payment information that we maintain related to your care.

This Notice describes how we handle your health information and your rights regarding this information. Generally speaking, we are required to:

- Maintain the privacy of your health information as required by law;
- Provide you with this notice of our duties and privacy practices regarding the health information about you that we collect and maintain;
- Follow the terms of our notice currently in effect

III. Contact Information

After reviewing this notice, if you need further information or want to contact us for any reason regarding the handling of your health information, please direct any communications to the following contact person:

Privacy Officer
Starr Psychiatric Center
529 Pearl Street
Brockton, MA 02301
(508) 580-2211

IV. Uses and Disclosures of Information

Under federal law, we are permitted to use and disclose personal health information without authorization for treatment, payment, and health care operations. However, the American Psychiatric Association's Principles of Medical Ethics or state law may require us to obtain your express consent before we make certain disclosures of your personal psychiatric information. Participants in this treatment center also share health information with each other as necessary to carry out treatment, payment, or health care operations relating to the care of our patients and for billing purposes.

Example of using or disclosing information for treatment:

- A nurse takes your pulse and blood pressure, records it in the medical record, and informs your doctor of the results.
- We discuss cases in a case conference with the senior psychiatrist for purposes of legal supervision (RN) or to improve clinical care.

Example of using or disclosing health information for payment:

- We submit a bill to your health insurer to receive payment for your care; the insurer askes for health information (for example, your diagnosis and what care we provided) in order to pay us. In such situations, we will disclose only the minimum amount of information necessary for this purpose.

Example of using or disclosing health information for health care operations:

- In the course of providing treatment to patients, we perform certain important functions such as quality assessment, training programs, credentialing, medical review, etc. In performing such functions, we may rely on certain business associates to assist us. We will share with our business associates only the minimum amount of personal health information necessary for them to assist us.

V. Other Uses and Disclosures

In addition to uses and disclosures related to treatment, payment, and health care operations, we may also use and disclose your personal information without authorization for the following additional purposes:

Abuse, Neglect, or Domestic Violence

- As required or permitted by law, we may disclose health information about you to a state or federal agency to report suspected abuse, neglect, or domestic violence. If such report is optional, we will use our professional judgment in deciding whether or not to make such a report. If feasible, we will inform you promptly that we have made such a disclosure.

Appointment Reminders and Other Health Services

- We may use or disclose your health information to remind your about appointments or to inform you about treatment alternatives or other health-related benefits and services that may be of interest to you, such as case management or care coordination.

Business Associates

- We may share health information about you with business associates who are performing services on our behalf. For example, we may contract with a company to service and maintain our computer systems, or to do our billing. Our business associates are obligated to safeguard your health information. We will share with our business associates only the minimum amount of personal health information necessary for them to assist us.

Communicable Diseases

- To the extent authorized by law, we may disclose information to a person who may have been exposed to a communicable disease or who is otherwise at risk of spreading a disease or condition.

Communications with Family and Friends

- We may disclose information about you to a persons who are involved in your care or payment for your care, such as family members, relatives, or close personal friends. Any such disclosure will be limited to information directly related to the person's involvement in your care.
- If you are available, we will provide you an opportunity to object before disclosing any such information. If you are unavailable because, for example, you are incapacitated or because of some other emergency circumstance, we will use our professional judgement to determine what is in your best interest regarding any such disclosure.

Coroners, Medical Examiners, and Funeral Directors

- We may disclose health information about you to a coroner or medical examiner, for example, to assist in the identification of a decedent or determining the cause of death. We may also disclose health information to funeral directors to enable them to carry out their duties.

Disaster Relief

- We may disclose health information about you to government entities or private organizations (such as Red Cross) to assist in disaster relief efforts.
- If you are available, we will provide you an opportunity to object before disclosing any such information. If you are unavailable because, for example, you are incapacitated, we will use our professional judgment to determine what is in your best interest and whether a disclosure may be necessary to ensure an adequate response to the emergency circumstances.

Food and Drug Administration (FDA)

- We may disclose health information about you to the FDA, or to an entity regulated by the FDA, in order, for example, to report an adverse event or a defect related to a drug or medical device.

Health Oversight

- We may disclose health information about you for oversight activities authorized by law or to an authorized health oversight agency to facilitate auditing, inspection, or investigation related to our provision of health care, or to the health care system.

Judicial or Administrative Proceedings

- We may disclose health information about you in the course of a judicial or administrative proceeding, in accordance with our legal obligations.

Law Enforcement

- We may disclose health information about you to a law enforcement official for certain law enforcement purposes. For example, we may report certain types of injuries as required by law, assist law enforcement to locate someone such as a fugitive or material witness, or make a report concerning a crime of suspected criminal conduct.

Minors

- If you are an emancipated minor under Massachusetts's ;aw, there may be circumstances in which we disclose health information about you to a parent, guardian, or other person acting in loco parentis, in accordance with our legal and ethical responsibilities.

Notification

- We may notify a family member, your personal representative, or other person responsible for you care, of your location, general condition, or death.
- If you are available, we will provide you an opportunity to object before disclosing any such information. If you are unavailable because, for example, you are incapacitated or because of some other emergency circumstance, we will use our professional judgment to determine what is in your best interest regarding any such disclosure.

Parents

- If you are a parent of an emancipated minor, and are acting as the minor's personal representative, we may disclose health information about your child to you under certain circumstance. For example, if we are legally required to obtain your consent as your child's personal representative in order for your child to receive care from us, we may disclose health information about your child to you.
- In some circumstances, we may not disclose health information about an emancipated minor to you. For example, if your child is legally authorized to consent to treatment (without separate consent from you), consents to such treatment, and does not request that you be treated as his or her personal representative, we may not disclose health information about your child to you without your child's written authorization.

Personal Representative

- If you are an adult or emancipated minor, we may disclose health information about you to a public health authority, for example, to report disease, injury, or vital events such as death.

Public Safety

- Consistent with our legal and ethical obligations, we may disclose health information about you based on a good faith determination that such disclosure is necessary to prevent a serious and imminent threat to the public or to identify or apprehend an individual sought by law enforcement.

Required by Law

- We may disclose health information about you as required by federal, state, or other applicable law.

Research

- We may disclose health information about you for research purposes in accordance with our legal obligations. For example, we may disclose health information without written authorization if an Institutional Review Board (IRB) or authorized privacy board has reviewed the research project and determined that the information is necessary for the research and will be adequately safeguarded.

Specialized Government Functions

- We may disclose health information about you for certain specialized government functions, as authorized by law. Among these functions are the following: military command; determination of veteran's benefits; national security and intelligence activities; protection of the President and other officials; and the health, safety, and security of correctional institutions.

Workers' Compensation

- We may disclose health information about you for purposes related to workers' compensation, as required and authorized by law.

VI. Psychotherapy Notes

In the course of your care with us, you may receive treatment from a mental health professional (such as a psychiatrist) who keeps separate notes during the course of your therapy sessions about your conversations. These notes, known as "psychotherapy notes", are kept apart from the rest of your medical record, and do not include basic information such as your medication treatment record, counseling session start and stop times, the types and frequencies of treatment you receive, or your test results. They also do not include summary of your diagnosis, condition, treatment plan, symptoms, prognosis, or treatment progress.

Psychotherapy notes may be disclosed by a therapist only after you have given written authorization to do so. (Limited exceptions exist, e.g. in order for your therapist to prevent harm to yourself or other, and to report child abuse/neglect). You cannot be required to authorize the release of your psychotherapy notes in order to obtain health insurance benefits for your treatment, or enroll in a health plan. Psychotherapy notes are also not among the records that you may request to review or copy (see discussion of your rights in section VII below). If you have any questions, feel free to discuss this subject with your therapist.

VII. Your Health Information Rights

Under the law, you have certain rights regarding the health information that we collect and maintain about you. This includes the right to:

- Request that we restrict certain uses and disclosures of your health information; we are not, however, required to agree to a requested restriction.
- Request that we communicate with you by alternative means, such as making records available for pick-up, or mailing them to you at an alternative address, such as a P.O. box. We will accommodate reasonable requests for such confidential communications.
- Request to review, or to receive a copy of, the health information about you that is maintained in our files and the files of our business associates (if applicable). If we are unable to satisfy you request, we will tell you in writing the reason for the denial and your right, if any, to request a review of the decision.
- Request that we amend the health information about you that is maintained in our files and the files of our business associates (if applicable). Your request must explain why you believe our records about you are incorrect, or otherwise require amendment. If we are unable to satisfy your request, we will tell you in writing the reason for the denial and tell

you how you may contest the decision, including your right to submit a statement (of reasonable length) disagreeing with the decision. This statement will be added to your records.

- Request a list of our disclosures of your health information. This list, known as an "accounting" of disclosures, will not include certain disclosures, such as those made for treatment, payment, or health care operations. We will provide you the accounting free of charge; however, if you request more than one accounting in any 12-month period, e may impose a reasonable, cost-based fee for any subsequent request. Your request should indicate the period of time in which you are interested (for example, "from May 1, 2003 to June 1, 2003"). We will be unable to provide you an accounting for any disclosures made before April 14, 2003, or for a period of longer than six years.

In order to exercise any of your rights described above, you must submit your request in writing to our contact person (see section III above for information). If you have any questions about your rights, please speak with our contact person, available in person or by phone, during normal office hours.

VIII. To Request Information of File a Complaint

If you believe your privacy rights have been violated, you may file a written complaint by mailing it or delivering it to our contact person (see section III above). You may complain to the Secretary of Health and Human Services (HHS) by writing to Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W. Room 509F, HHH Building, Washington, D.C. 20201; by calling 1-800-368-1019; or by sending an email to OCRprivacy@hhs.gov. We cannot, and will not, make you waive your rights to file a complaint with HHS as a condition of receiving care from us, or penalize you for filing a complaint with HHS.

IX. Revisions to this Notice

We reserve the right to amend the terms of this Notice. If this Notice is revised, the amended terms shall apply to all health information that we maintain, including information about you collected or obtained before the effective date of the revised Notice. If the revisions reflect a material change to the use and disclosure of your information, your rights regarding such information, our legal duties, or other privacy practices described in the Notice, we will promptly distribute the revised Notice, post it in the waiting area(s) of our Center, and make copies available to our patients and others.

X. **Effective Date:** April 14, 2003