Kristen Joyce, LMHC

**Address:** 25 Main Street, Suite 201, Northampton MA, 01060

**Telephone:** 978-697-3903

**Email:** Kristen@KristenJoyce.com

**New Participant Information**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/State/zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security Number: \_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: \_\_\_\_\_\_ Marital Status: \_\_\_\_

May I contact you at this phone number? Y N May I email you? Y N

Primary Care Physician Name and Office Phone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any known allergies? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a history of mental health treatment? If so, please describe. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a history of substance abuse and/or substance abuse treatment? If so, please describe.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any medications you are currently taking. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who prescribes these medications? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you seen another therapist over the past year? If so, how many times? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Name/Relation/Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about me? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Financial Responsibility**

Are you using insurance or paying privately for this service? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you are paying privately, what amount do you agree to pay per session? \_\_\_\_\_\_\_\_\_\_\_\_\_

If you are using insurance please provide the following:

Insurance company name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance ID number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber’s date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber’s relationship to you: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Copayment amount: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Service Contract**

**Consent to Treatment:** I consent to receive psychotherapy from Kristen Joyce (here after referred to as Kristen). I understand that my consent is voluntary, that I do not have to accept any treatment option Kristen offers and that I may withdraw my consent at any time.

Initial\_\_\_\_\_\_\_\_\_\_\_\_

**Treatment Sessions:** I understand that standard treatment sessions are 45 minutes in length and that some exceptions may occur. If I am unable to keep an appointment I agree to notify Kristen at lease 24 hours in advance. I understand that I will be charged the full session rate for all sessions cancelled without 24 hour notice.

Initial\_\_\_\_\_\_\_\_\_\_\_\_

**Financial Responsibility:** I acknowledge that I am responsible for payment for all services, regardless of whether I have insurance coverage. If I have insurance I understand that I am responsible for knowing the specific terms and limits of my coverage, and that I am ultimately responsible for full payment of fees if insurance should fail to pay for any reason.

Initial\_\_\_\_\_\_\_\_\_\_\_\_

**Billing Authorization and Release of Information:** I authorize Kristen to bill my insurance company for her services and to release my individually identifiable health information necessary to process insurance claims. I understand that my individually identifiable health insurance information will also be released to Kristen’s billing services. I understand that this authorization is voluntary and that if the organization authorized to receive the information is not a health plan or healthcare provider the information may no longer be protected by federal privacy regulations.

Initial\_\_\_\_\_\_\_\_\_\_\_\_

**Assignment of Benefits:** I authorize that the payment of my insurance benefits should be made directly to Kristen Joyce for services performed.

Initial\_\_\_\_\_\_\_\_\_\_\_\_

**No-Show/Last Minute Cancelation Policy:** I acknowledge that I am responsible for payment to Kristen Joyce for sessions which I consented to schedule but then canceled without 24-hour-notice or no showed. I understand that I am responsible for the full session cost under these circumstances. I am aware that the full session cost is $\_\_\_\_\_. (To be discussed with therapist)

Initial\_\_\_\_\_\_\_\_\_\_\_\_

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**Contacting Therapist:** I am aware that contact is allowed between sessions with Kristen Joyce through phone, text, e mail and other online forums (ie webpage and professional facebook page) generally for scheduling purposes. I am aware that Kristen may not be able to respond to me immediately and, in the case of an emergency I should contact my local emergency services provider or 911. I also acknowledge that the only truly secure form of communication is phone. Kristen is not therefore responsible if personal information is transmitted to inappropriate sources through other forms of contact. Also, if you must cancel an appointment, please make sure to call in order to ensure 24 hour notice is given.

Initial\_\_\_\_\_\_\_\_\_\_\_\_

**Treatment Risk and Benefits:** The primary goals of psychotherapy are to support participants in increasing their abilities to respond effectively to emotions, events and interpersonal difficulties. As is true of all types of treatment, individuals may experience uncomfortable emotions like sadness, anxiety or anger during the process. Participants are also expected to experience reduction of unwanted behaviors and emotions, improvements in ability to manage interpersonal conflicts and increased confidence and competence in a number of realms. There is no way to guarantee what the process or outcome will involve for each individual.

Initial\_\_\_\_\_\_\_\_\_\_\_\_

**Professional Records:** The law and standards of psychotherapy require that treatment records are kept. These records will be kept confidential in a secure location.

Initial\_\_\_\_\_\_\_\_\_\_\_\_

**Confidentiality:** As a psychotherapist Kristen Joyce agrees to follow confidentiality standards of the field of psychotherapy. This means that, in general, the law protects the privacy of all communications between participant and therapist and Kristen Joyce can release information about a client to others only with the participant’s written consent. However, there are a few exceptions of which participants should be aware:

* In most legal proceedings, participants have the right to prevent Kristen Joyce from providing any information about their treatment. However, in some situations involving child custody and those in which a participant’s emotional condition is an important issue, a judge may order our testimony if he or she determines that the issues demand it. There are some situations in which we are legally obligated to take action to protect others from harm, even if we must reveal some information about a participant’s treatment. This is the case in situations where it is our belief that a child, elderly person or disabled person is being abused or if we believe that a participant is threatening serious bodily harm to him or herself or someone else. Actions that Kristen Joyce may be required to take in such cases include but are not limited to: contacting the potential victim, alerting law enforcement, filing a report with a state protective agency, contacting the participants’ designated emergency contacts or seeking hospitalization for the participant. These situations have rarely occurred in Kristen Joyce’s practice and experience. If a similar situation should occur, Kristen Joyce will make every effort to avoid revealing participants’ identities and personal information as well as to alert the participant to the situation and work with the participant to identify and prepare for steps that must be taken.
* In complicated cases Kristen Joyce may find it necessary to consult with other professionals about a case. In this situation she would continue to make every effort to avoid revealing the identity of participants. Any consultant is also legally bound to maintain confidentiality. Unless a participant objects, Kristen Joyce will not alert participants about these consultations unless she feels that it is vital to our work together.

While this written summary of exceptions to confidentiality should prove helpful in informing clients about potential problems, participants’ questions or concerns regarding this information are welcome. If you would like a copy of the HIPAA Privacy Notice, which regules privacy and confidentiality please ask and Kristen will provide you with one.

Initial\_\_\_\_\_\_\_\_\_\_\_\_

**Acknowledgement:**

I, the above named participant, hereby acknowledge that my initials above and signature below are confirmation that I understand and accept the terms and conditions of this authorization and agreement.

Signature and Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_