Daniel J. Richard, Ph.D.
Licensed Clinical Psychologist

720 Washington St. Suite 203 Hanover, MA 02339
(ph) 617-615-9402 (fx) 844-629-3635
DrDanielJRichard.com email@DrDanielJRichard.com

Please PRINT and BRING WITH YOU to your first session

Family Information

Date_ _ /_ _ /_ _ _ _ Social Security Number _ _ _ -_ _ -_ _ _ _

Name _____ DOB_ _ /_ _ /_ _ _ _ Gender M F
Address _____ Home Phone ( ) _ _ _-_ _ _ _
_____ Work Phone ( ) _ _ _-_ _ _ _
Mobile Phone ( ) _ _ _-_ _ _ _
Email: _____
If we contact you to change an appointment, where should we call/text? _____
May we identify ourselves when we leave messages YES NO
Emergency Contact and Phone #_____
Referred by:_____
Marital Status: S M D W Other please specify_____
Occupation:_____Education_____
For billing purposes, have you seen a mental health professional since January first of this year? If so, please explain:_____

Family Member's Name	DOB	Relationship to Patient
	/ /	
	/ /	
	/ /	
	/ /	
	/ /	
	/ /	
Others Living in the Household		
	/ /	
	/ /	

Physician: _____Address_____
Phone:_____Date of last physical: _____

Significant Medical History/Medications both prescribed and over the counter: _____
_____
_____
_____
_____

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CLIENT INFORMATION AND FINANCIAL AGREEMENT

APPOINTMENTS:
Standard appointments are approximately 45 to 60 minutes long. Extended sessions and telephone appointments are available by prior agreement; these are NOT covered by insurance and are billed at my hourly rate.

TELEPHONE CALLS and E-MAIL:
I may be reached and messages left at the number above. I make every effort to return messages within a day. On rare occasions my voicemail or service may fail to record messages in full, so if I have not returned a message within 24 hours, please call again. If you have a medical emergency requiring immediate attention, please seek help as directed by your medical insurance carrier or at your nearest emergency room. Your message is also transcribed and emailed to me (via Google voice).

Extended telephone calls (more than 5 minutes) will be billed at my hourly rate, but brief calls and appointment scheduling are not billed.

Email may be sent to **email@DrDanielJRichard.com** I usually check my email daily, but urgent messages and appointment changes are best made through my telephone number. Since I cannot guarantee that email messages are secure, please do not include sensitive personal information in such communications.

CANCELLATIONS and MISSED APPOINTMENTS POLICY:
Hours set aside for you or your family are not easily filled when they are cancelled on short notice. Therefore, you will be billed for appointments cancelled with less than 24 **business hours** notice. That is, if you are canceling a Monday or Tuesday appointment you must call by the end of the previous week to avoid a charge. This gives me a chance to schedule your hour with another client. The charge for late cancellations and missed appointments will be $100.00. Please note that **insurance does not cover these charges.**

Exceptions to policy:
If you cancel with less than 24 hours notice and are able to reschedule within the same week at another time I have available, you will not be billed for the late cancellation. Other exceptions include cancellations due to sudden illness of yourself or your immediate family member, hazardous driving conditions, or certain other emergencies. These exceptions are at my discretion. Appointments missed or cancelled late due to work or school obligations will be billed to you; therefore, please schedule your appointments when your other commitments will not interfere.

INSURANCE and FEE PAYMENT: I will do whatever I can to clarify insurance matters and to provide documentation to secure insurance payment, but it is your responsibility to understand your insurance coverage, including coverage and copayments, and to pay for non-covered

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services. If we must bill for co-pays a $15.00 fee will be assessed for each co-pay billed. If you would like a receipt for payment please let me know in advance. For insurance plans and managed care contracts that I do not affiliate with, I will provide you with an itemized bill that you can submit for any reimbursement due you.

Adjustments to fees and deferred payment arrangements can be negotiated for reasons of financial need if discussed in advance. Balances unpaid beyond 30 days are subject to charges of 1.5% per month**.**

EXTENDED TREATMENT and INSURANCE:
In order for treatment to be covered by insurance it must be considered "medically necessary." Medically necessary care is defined as treatment for a condition which causes significant emotional distress and/or impaired functioning, and for which treatment is appropriate and judged effective. This may cause confusion for the client who believes that he or she is entitled to a certain number of sessions under an insurance plan, but whose condition does not meet the above criteria. Additionally, many clients experience a reduction in symptoms and improvement in functioning but wish to continue therapy. In fact, the benefits of therapy extend beyond that considered medically necessary, but insurance is not designed to cover such treatment. It is important for each client to understand what insurance will and will not cover, as well as the option to contract for services beyond those limits. Please feel free to discuss these matters with me as you see fit.

SCHOOL VISITS and OTHER SERVICES:
School visits are not covered by insurance and are billed at my hourly rate. Extended clinical reports (e.g., disability reports) court testimony, and other consultations are also not covered by insurance and are billed to the client, including travel time and waiting time.

TELEPSYCHOLOGY

Benefits and Risks of Telepsychology
Telepsychology refers to providing psychotherapy services remotely using telecommunications technologies, such as video conferencing or telephone. One of the benefits of telepsychology is that the client and clinician can engage in services without being in the same physical location. This can be helpful in ensuring continuity of care if the client or clinician moves to a different location, takes an extended vacation, or is otherwise unable to continue to meet in person. It is also more convenient and takes less time. Telepsychology, however, requires technical competence on both our parts to be helpful. Although there are benefits of telepsychology, there are some differences between in-person psychotherapy and telepsychology, as well as some risks. For example:

- Risks to confidentiality. Because telepsychology sessions take place outside of the therapist's private office, there is potential for other people to overhear sessions if you are not in a private place during the session. On my end I will take reasonable steps to ensure your privacy. But it is important for you to make sure you find a private place for our session where you will not be interrupted. It is also important for you to protect the privacy of our session on your cell phone or other device. You should participate in

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therapy only while in a room or area where other people are not present and cannot overhear the conversation.

- Issues related to technology. There are many ways that technology issues might impact telepsychology. For example, technology may stop working during a session, other people might be able to get access to our private conversation, or stored data could be accessed by unauthorized people or companies.

- Crisis management and intervention. Usually, I will not engage in telepsychology with clients who are currently in a crisis situation requiring high levels of support and intervention. Before engaging in telepsychology, we will develop an emergency response plan to address potential crisis situations that may arise during the course of our telepsychology work.

- Efficacy. Most research shows that telepsychology is about as effective as in-person psychotherapy. However, some therapists believe that something is lost by not being in the same room. For example, there is debate about a therapist's ability to fully understand non-verbal information when working remotely.

Electronic Communications

We will decide together which kind of telepsychology service to use. You may have to have certain computer or cell phone systems to use telepsychology services. You are solely responsible for any cost to you to obtain any necessary equipment, accessories, or software to take part in telepsychology.

For communication between sessions, I only use email communication and text messaging with your permission and only for administrative purposes unless we have made another agreement. This means that email exchanges and text messages with my office should be limited to administrative matters. This includes things like setting and changing appointments, billing matters, and other related issues. You should be aware that I cannot guarantee the confidentiality of any information communicated by email or text. Therefore, I will not discuss any clinical information by email or text and prefer that you do not either. Also, I do not regularly check my email nor do I respond immediately, so these methods **should not** be used if there is an emergency.

Treatment is most effective when clinical discussions occur at your regularly scheduled sessions. But if an urgent issue arises, you should feel free to attempt to reach me by phone. I will try to return your call within 24 hours except on weekends and holidays. If you are unable to reach me and feel that you cannot wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist or psychiatrist on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact in my absence if necessary.

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Confidentiality
I have a legal and ethical responsibility to make my best efforts to protect all communications that are a part of our telepsychology. However, the nature of electronic communications technologies is such that I cannot guarantee that our communications will be kept confidential or that other people may not gain access to our communications. I will try to use updated encryption methods, firewalls, and back-up systems to help keep your information private, but there is a risk that our electronic communications may be compromised, unsecured, or accessed by others. You should also take reasonable steps to ensure the security of our communications (for example, only using secure networks for telepsychology sessions and having passwords to protect the device you use for telepsychology).

The extent of confidentiality and the exceptions to confidentiality that I outlined in my standard Informed Consent provided on my website still apply in telepsychology. Please let me know if you have any questions about exceptions to confidentiality.

Appropriateness of Telepsychology
From time to time, we may schedule in-person sessions to "check-in" with one another. I will let you know if I decide that telepsychology is no longer the most appropriate form of treatment for you. We will discuss options of engaging in in-person counseling or referrals to another professional in your location who can provide appropriate services.

Emergencies and Technology
Assessing and evaluating threats and other emergencies can be more difficult when conducting telepsychology than in traditional in-person therapy. To address some of these difficulties, we will create an emergency plan before engaging in telepsychology services. I will ask you to identify an emergency contact person who is near your location and who I will contact in the event of a crisis or emergency to assist in addressing the situation. I will ask that you sign a separate authorization form allowing me to contact your emergency contact person as needed during such a crisis or emergency.

If the session is interrupted for any reason, such as the technological connection fails, and you are having an emergency, do not call me back; instead, call 911, or go to your nearest emergency room. Call me back after you have called or obtained emergency services.

If the session is interrupted and you are not having an emergency, disconnect from the session and I will wait two (2) minutes and then re-contact you via the telepsychology platform on which we agreed to conduct therapy. If you do not receive a call back within two (2) minutes, then call me on the phone number for the office (617-615-9402).

If there is a technological failure and we are unable to resume the connection, you will only be charged the prorated amount of actual session time.

Fees
The same fee rates will apply for telepsychology as apply for in-person psychotherapy. However, insurance or other managed care providers may not cover sessions that are conducted via

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telecommunication. If your insurance, HMO, third-party payor, or other managed care provider does not cover electronic psychotherapy sessions, you will be solely responsible for the entire fee of the session. Please contact your insurance company prior to our engaging in telepsychology sessions in order to determine whether these sessions will be covered.

Records

The telepsychology sessions shall not be recorded in any way unless agreed to in writing by mutual consent. I will maintain a record of our session in the same way I maintain records of in-person sessions in accordance with my policies.

AUTHORIZATION FOR BILLING and FINANCIAL AGREEMENT:

I hereby authorize Dr. Daniel J. Richard to bill my medical insurance carrier, or other third party specifically designated by me, for services rendered, and I give permission to Dr. Richard to provide the diagnosis, type of service, and dates of service which are required to obtain payment from insurance providers and their reviewers. This authorization also includes additional clinical information which may be required for peer review or for extended benefits. If you do not wish for information to be disclosed to an insurance company or other party, you may choose to contract for services on a self-pay basis.

I agree to assume full financial responsibility for all fees not covered by my medical insurance carrier or other third party. I understand that I will be charged directly at the prevailing hourly rate for all appointments cancelled with less than 24 business hours notice, and for appointments not kept, as well as for extended telephone calls and treatment not authorized and covered by insurance.

Rates of service vary depending on specific services rendered and are adjusted from time to time due to inflation and other costs of doing business. See separate *Fee Schedule*.

I also agree to have my credit card number held on file for billing purposes. A monthly invoice will be sent for copays, deductible, late cancellation fees, etc. and is due upon receipt. There is a small fee for this service. See *credit card authorization* below.

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Insurance Provider Behavior Health Information

Client Name: _____

Medical Insurance Carrier:

_____

Insurance Carrier Contact Info for Behavioral Health Coverage

Phone: (_ _ _) _ _ _-_ _ _ _ **Employer:**

Address: _____

_____ **Plan Name:**

_____ _____

_____ **Policy #:**_____

Cardholder Name:

_____ **Cardholder SSN:** _ _ _-_ _-_ _ _ _

Phone: (_ _ _**)** _ _ _-_ _ _ _ **Date Insurance Effective:** _ _-_ _-_ _ _ _

Type of Policy: Individual Family (circle one)

Client Name: _____**Date**_____

_____
Signature of client, parent, or authorized person

Witness name: _____ **Date**_____

_____
Witness Signature

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Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐Other _____
Cardholder Name (as shown on card): _____
Card Number: _____
Expiration Date (mm/yy): _____
Security Code:
Cardholder ZIP Code (from credit card billing address): _____

I, _____, authorize Daniel J. Richard, Ph.D. to charge my credit card above for agreed upon services. I understand that my information will be saved to file for future transactions on my account.

Customer Signature Date

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Fee Schedule

Initial Appointment (45-60 minutes)	$220.00
Follow-up Session (45-53 minutes)	$170.00
Extended Session	$65.00 per 15 minutes or fraction thereof
Group Therapy (90 minutes)	$80.00
Family Therapy (90 minutes)	$270.00
Psychological /Evaluative/Consultative Assessment:	$220.00/hr, including report preparation
Court Appearances:	$220.00/hr including travel, waiting time, and expenses.
Missed/Late Cancellations	$100.00
Record Requests	$ .50 per page

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Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully, then PRINT and SIGN at the bottom and BRING to your first appointment.

Protecting patient privacy is an important element of the trust between my practice and my patients, and an important legal and ethical obligation. I am deeply committed to protecting my patients' rights to privacy, and to safeguarding patient information.

Note regarding Minor Children: If the person under treatment is a minor child, this notice should be understood as applying to that child's Protected Health Information. In the case of an adolescent minor, I shall inform him or her of the information included in this Notice, if in my judgment this is developmentally appropriate.

My Responsibilities:

My practice is required to maintain the privacy of your Protected Health Information ("Health Information"). This includes medical information about you that is collected during the course of your treatment, such as your symptoms, examination and test results, diagnoses, treatment, and a plan for future care. Information about care that you have received from other providers may also be included in your medical record. Health Information also includes demographic information and payment information.

I am required by law to provide you with this Notice of Privacy Practices. This Notice describes how I use your Health Information within my practice, and disclose ("share") it with others. My practice must abide by the terms of the Notice currently in effect. I reserve the right to change the terms of my Notice and to make the new Notice provisions effective for all Health Information that it maintains. I will post my current Notice on my website:DrDanielJRichard.com.

I. Uses and Disclosures of your Health Information:

The following are examples of the types of uses and disclosures of your Health Information that my practice is legally permitted to make.

A. **Uses and Disclosures of Health Information for Treatment. Payment and Operations**
Your Health Information may be used for your care and treatment. Your Health Information may also be used and disclosed as necessary for me to obtain reimbursement for care provided to you, and to support the operation of my practice.

1. **Treatment:** I may use your Health Information to provide and manage your health care. If I refer you for treatment - for example to another clinician or hospital - I will provide that health care provider with the necessary information to diagnose or treat you. In addition, I will ask your permission to share your Health Information with other health care providers who care for you, or who may consult with us about your care. I believe this is critical to provide you the very best in health care and is necessary given the complexities of various illnesses and health conditions

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2. **Payment:** I may use and disclose your Health Information, as needed, to obtain payment for health care services. I may disclose information to your insurance company or third party payer in order to make sure your treatment is authorized, to verify eligibility or coverage for insurance benefits, and to permit the payer to review services provided to you for medical necessity.

3. **Healthcare Operations:** My practice may use or disclose your Health Information in order to conduct its business of providing health care. For example, if your insurance company requires information about your symptoms and/or functioning, in order to verify that services I provide are medically necessary and thus are covered by insurance, I will share only what information is necessary for this determination.

B. Other Permitted and Required Uses and Disclosures of Your Health Information:
In addition to treatment, payment and healthcare operations, there are other circumstances in which I am either permitted or required to disclose your Health Information, in accordance with applicable law.

L **Involvement of Others in Your Health Care:** I will make an effort to ask you if I may share relevant Health Information about you with family members or any other person you identify. If you are not present, unable to communicate, or in an emergency situation, I may exercise my professional judgment to determine whether to share this information. In addition, I may need to disclose Health Information to notify a family member or any other person responsible for your care of your location, general condition or death. Finally, I may disclose your Health Information to an authorized public or private entity to assist in disaster relief efforts, and to coordinate efforts to notify someone on your behalf. Please be assured I will only do so if absolutely necessary and in the event of an emergency or disaster.

2. **Public Health:** I may disclose your Health Information for public health activities, including the following:
   - to report Health Information (e.g., infectious diseases, such as chickenpox) to prevent or control disease, injury, or disability
   - to report births and deaths
   - to report reactions to medications or problems with products
   - to notify a person who may have been exposed to a communicable disease, or may be at risk for contracting or spreading the disease

3. **Victims of Abuse. Neglect or Domestic Violence:** If I reasonably believe you are a victim of abuse, neglect or domestic violence. I may disclose your Health Information to an appropriate agency authorized by law to receive such reports.

4. **Legal Proceedings:** I may be required to disclose Health Information in the course of any judicial or administrative proceeding in response to a legal order or other lawful process, including a subpoena.

5. **Law Enforcement:** I may be required to disclose Health Information for law enforcement purposes.

6. **Coroners. Funeral Directors and Organ Donation:** I may be required to disclose Health Information to a coroner or medical examiner to identify a deceased person or to determine the cause of death. I may also disclose Health Information to a funeral directors or their designee, as necessary to carry out their duties. Health Information may also be disclosed to organizations that facilitate organ, eye or tissue donation and transplantation.

7. **To avert a serious threat to health or safety:** I may be required to use and disclose Health Information to prevent or lessen a serious threat to a person's or the public's health or safety. If I believe that there is a

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credible threat of harm to an identifiable person, I am obligated to take action to safeguard that person, including notifying the appropriate law enforcement authorities.

8. **Specialized Government Functions:** Under certain circumstances, I may be required to disclose Health Information to units of the government with special functions, such as the U.S. military or the U.S. Department of State.

9. **Required By Law**: I may be required to use or disclose your Health Information to the extent that the use or disclosure is required by federal, state or local law. This includes any other law not already referred to in the preceding categories. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law.

10. **If I am unable to continue my practice:** In the unlikely event that I am incapacitated or otherwise unable to continue my practice, I have arranged for a competent and experienced colleague to provide interim consultation or other care to my patients. In order to provide this necessary care, my colleague will be provided access to your clinical and billing records. It is your right, of course, to select a clinician of your own choice, to continue your treatment.

C. Uses and Disclosures of Health Information Based upon Your Written Authorization

Uses and disclosures of your Health Information, other than those described above, will be made only with your written authorization.

In addition, federal and Massachusetts laws require that I obtain your specific written authorization for the use or disclosure of certain information about you. This information includes psychotherapy "process notes" as defined by federal law; communications with certain behavioral health professionals; communications between domestic violence victims and domestic violence counselors, and between sexual assault victims and sexual assault counselors; and information related to substance abuse treatment, HIV testing or test results, treatment of sexually transmitted diseases, and genetic testing or test results.

II. Your Individual Rights

Although your medical record at my practice is my property, health information contained therein belongs to you. The following is a statement of your rights with respect to your Health Information, and a brief description of how you may exercise these rights.

A. You have the right to inspect and copy your Health Information. At any time, you may inspect and obtain a copy of Health Information about you, including your medical and billing record, which may be used to make decisions about your care. Under limited circumstances I may limit your access to all or certain portions of your record. This includes, but is not limited to, psychotherapy "process" notes, or information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding. If you are denied access to portions of your record, in some circumstances you may have a right to have this decision reviewed. All requests to access your record must be made in writing to me, and will be processed within 30 days. If you request a copy of your records, I may charge you a fee to cover the copying and mailing costs.

B. You have the right to request an amendment of your Health Information. You may request me to amend your treatment and billing information if you think the information is incorrect or incomplete, for as long as I maintain

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the information.

C. <u>You have the right to request a restriction of your Health Information.</u> You have the right to ask in writing for restrictions on the use and sharing of your health information for treatment or payment. If this information is needed for insurance payment, you will be liable for any charges you incur. Despite the preceding, if you need to be treated in an emergency, I may be required to share information needed for your care. You may not ask me to restrict uses and sharing of information that I am legally required to make. All requests must be in writing to my office.

D. <u>You have the right to receive an accounting of certain disclosures I have made, if any, of your Health Information.</u> This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice. It does not apply to disclosures I may have made to you, that were authorized by you, information provided to family members or friends about your care, or for notification purposes. You have the right to receive specific information regarding disclosures made by me that occurred after February 15, 2009. You can request an accounting of disclosures for a period up to six years, but only for disclosures made after February 15, 2009. The right to receive this information is subject to certain exceptions, restrictions and limitations. Requests must be made in writing to me, and I will respond to your request within 60 days.

E. <u>You have the right to obtain a paper copy of this notice.</u> I will provide a paper copy of this Notice to you, upon request.

III. <u>Effective Date:</u> This Notice is effective on March 23, 2020

IV. <u>Complaint Process:</u>

If you believe I have violated your privacy rights, please communicate your concerns to me at the earliest possible date. I will not retaliate against you if you file a complaint about my privacy practices, nor will it affect your rights or status as a patient with me. I will make every effort to respond to your concerns immediately and professionally.

Please contact me if you have questions or concerns about this policy.

I ----------
(print your name here).

have read this Notice of Privacy Practices.

(Signature)

Date ----------