ADDICTION RECOVERY SERVICES PLLC **Greenland IOP**
New Patient Information Packet **Eve___ Day___**
Patient Information

First Name: _____ Middle Initial: _____

Last Name: _____Gender: M F

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Cell Phone: ( ) _____ SSN:_____

Home Phone: ( ) _____ Birth Date: _____

Employed by:_____ Position:_____

Very Important: Which of these telephone numbers may we use if we need to contact you?_____ AND In the event we need to contact you by telephone, who may we speak with or leave a message with, other than yourself? _____

How were you referred to this office?

_____

Patient & Family Information

Please check one: [ ] Single [ ] Married [ ] Other

Please check one: [ ] Employed [ ] Full-Time Student [ ] Part-Time Student

List Family Members/Significant Other Names:

_____

Self-Pay Rate:_____

OR

Insurance Information: ***We require proof of insurance at your appointment. Please complete this section so we can process your claim.)***

Patient's ID #: _____ Insurance Company: _____

Subscriber's SSN: _____ (Subscriber is the person who holds the insurance policy.)

Subscriber's Last Name: _____

Subscriber's First Name: _____ Middle Initial: _____

Patient Relationship to Subscriber: [ ] Self [ ] Spouse [ ] Child [ ] Other

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: ( ) _____ Work Phone: ( ) _____

Subscriber's Birth Date: _____ Subscriber's Employer:_____

I hereby authorize Addiction Recovery Services to release any billing information to "Party Responsible for Payment" (Parent or Guardian signature if patient is a minor)

Patient's Signature: _____ Date: _____

IOP – PATIENT SERVICES AGREEMENT

Welcome to Addiction Recovery Services Intensive Outpatient Program (IOP). This document (the Agreement) contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a new federal law that provides new privacy protections and new patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) which you will receive with this agreement, for the use and disclosure of PHI for treatment, payment and health care operations. The Notice explains HIPAA and its application to your personal health information in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this information at the end of the first session. Although these documents are long and sometimes complex, it is very important that you read them carefully. We can discuss any questions you have. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on me unless I have already taken action in reliance on it; if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

IOP Services

During the first session, a comprehensive assessment will help us identify your goals for treatment. Substance abuse treatment has both benefits and risks. While it has been shown to have benefits for people who invest in the process with commitment and realistic expectations, it also has risks that may include experiencing uncomfortable feelings or recalling unpleasant aspects of your history. These are common feelings when trying something new. Sobriety often leads to a significant reduction in feelings of distress, better relationships, and resolution of problems. However, we cannot guarantee any particular resolution to problems or a particular response to treatment. *Treatment involves a commitment of time, money, and energy. The IOP Program does its best to try to help you address your issues. If you have questions about any procedures, it is important to discuss them with us.*

Office Hours and Emergency Contact

The IOP staff is at the office during the following IOP Program hours: Monday, Tuesday, Thursday, Friday from 9AM-7PM. The Greenland office number is 603-433-6250 and the admissions line is 978 228 5853. There is a voicemail service when the office is closed should you need to leave a message. We make every effort to return calls promptly. The program cell phone number is 978 228 5853, it is not an emergency service, but can be used to contact the program outside the above listed hours. For psychiatric or medical emergencies related to substance use, please call the Psychiatric Assessment and Referral Service (PARS) at the Portsmouth Regional Hospital, 603-436-0600, or proceed to your local emergency room.

Cancelled or Missed Appointment

Your appointment reserves your space in the IOP program. Once you have started the program, your attendance is recommended as often as possible. Please report any absence to IOP staff prior to the start of the group session. Repeat absences may result in referral to a higher level of care or discharge from our program. We will give our best effort to support you as long as you maintain contact.

Confidentiality

A. General

In order for treatment to be successful, it is often necessary to safely reveal private, sensitive information about yourself in the course of the IOP program. Ethically and legally, all of us here are bound to keep all of this information strictly confidential. The law protects the privacy of all communications between a patient and a clinical provider. In most situations, I can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. Your signature on this Agreement provides consent for those activities, as follows:

The IOP clinicians work as a team and consult with each other regarding all IOP patients. You should be aware that we employ administrative staff. In most cases, we need to share protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing and quality assurance. All of the mental health professionals are bound by the same rules of confidentiality. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a clinical provider.

Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.

There are certain conditions under which confidentiality may be breached:
_____initial

- If a patient threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her, or to contact family members or others who can help provide protection.
- If you disclose that a child or an elderly person is being sexually or physically abused, it must be reported to the proper authorities.
- If you are a danger to yourself or someone else, I must do whatever is necessary to protect you and/or the other person. The other person would have to be warned and the police notified.
- In legal proceedings, the courts usually respect your rights to confidentiality in the therapeutic relationship, and I am ethically bound to protect that right when testifying in legal or administrative proceedings. However, a judge could court order me to testify in certain situations, such as a contested custody proceeding in a divorce and, under these circumstances, we must do so.
- If a government agency is requesting the information for health oversight activities, I may be required to provide it.
- If a patient files a lawsuit against me, I may disclose relevant information regarding the patient in order to defend myself.

It is our practice, whenever possible, to discuss any imminent breaches of confidentiality with you before taking any action and we will limit our disclosure to the minimum necessary.

It is our practice to consult with colleagues within the practice regarding clinical matters. If you know someone within the practice in a nonprofessional capacity, please inform us right away.

B. Professional Records and Patient Rights
The laws and standards of our profession require that we keep Protected Health Information about you in your Clinical Record. HIPAA provides you with several new or expanded rights with regard to your Clinical Records and disclosures of protected health information. These rights include requesting that we amend your record; requesting restrictions on what information from your Clinical Records is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about our policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the Notice form, and our privacy policies and procedures. You may examine and/or receive a copy of your Clinical Record, if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, we recommend that you initially review them with IOP clinicians, or have them forwarded to another mental health professional so you can discuss the contents. In most circumstances, we are allowed to charge a copying fee of $15.00 for the first 30 pages or 50 cents per page, whichever is greater .

C. Couples and Families
You, as the patient of the IOP program, are the primary focus of treatment. Oftentimes, family members are included. Personal information (PHI) will not be shared with family members and/or significant others without your direct ***written consent.***

D. Group Therapy
In group therapy, any and all information shared within the group sessions by any group member must be kept confidential consistent with the limits to confidentiality listed above.

E. Office Policies
All administrative and office staff are bound to confidentiality and cannot disclose any information. This becomes especially sensitive when relatives call the office requesting even simple information, such as an appointment time for their spouse. Even under these simplest of situations, the office personnel cannot acknowledge they even know the person, nor can they disclose any information. If ongoing contact is to occur with a relative, regarding billing for example, then a release of information form can be signed, specifying the information that is permitted to be exchanged. All requests for records must be accompanied by a signed release of information. It is our office policy to keep records for 10 years from the date the record becomes inactive.

Insurance Reimbursement and Patient Balances

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. We accept assignment of insurance benefits from most insurance companies for your primary insurance only. However, we do request co-payments be paid in full at the time of service. The balance is your responsibility whether your insurance company pays us or not. Your insurance policy is a contract between you and your insurance company and we are not a party

to that contract. Please be aware that in some cases the services provided may be considered non-covered services by your insurance plan. At times, we won't be aware of final coverage until after claims are submitted and you have completed the IOP.
If you incur uncovered fees we can discuss a resolution and payment plan with you.
_____initial

We recommend carefully reading the section in your insurance coverage booklet that describes mental health services. Your coverage, co-payments, and benefits could be quite different from your regular medical coverage. If your insurance plan includes a managed care component, you may be required to obtain preauthorization and your coverage may be limited. IOP clinicians will be in contact with your insurance company following the initial evaluation to obtain preauthorization for IOP treatment and throughout your participation in the program should additional sessions be indicated.

We want to advise you that most insurance agreements require you to authorize us to provide basic clinical information such as diagnosis and treatment plans. Occasionally an entire copied record is required. While it is our policy to release only the minimum necessary information required to activate your insurance benefits, you need to be aware that we cannot control its use by your insurance company. Any concerns you may have about confidentiality of managed care records should be directed to the managed care company.

Some insurance companies require that we send billing and other information electronically (e.g., by facsimile or e-mail). The confidentiality of such communications cannot be guaranteed. If you do not consent to electronic communications, please inform the office immediately, before beginning treatment, so that we can determine whether and how to proceed. Once information about your insurance coverage has been determined, it is important for you to discuss with your clinical provider what can be accomplished with the benefits that are available, and what will happen should your benefits expire before you feel ready to end treatment. It is important to remember that you always have the right to pay for services yourself and not involve your health insurer at all.

In Closing
It is important that you understand and are comfortable with the issues outlined above. Please bring up any questions or concerns you might have.

Please Sign

I have read and accept the terms outlined on the previous pages.

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Signature of patient or legal representative Date

CONSENT TO RELEASE INFORMATION

I authorize my clinical provider to release and exchange medical information as necessary to my insurance carrier.

I will provide current, updated or changed insurance information throughout my course of treatment.

I understand that my insurance will be billed by the Office with the proper information provided.

I understand that this does not guarantee insurance payment to the clinical provider and that any outstanding balance is my responsibility.

I understand that regardless of insurance coverage, I must settle my account within sixty (60) days.

I further understand that I may revoke this authorization at any time should I desire by notifying this office in writing.

Name of Patient: _____

Signature of Patient or Legal Representative: _____ Date:_____

Provider: _____ Date: _____

Receipt of HIPAA Notification:_____Date:_____