Linda Benoit, LICSW, ICADC, CADC
Private Psychotherapy & Addiction Services
p: 413-552-7065

1866 Northampton Street
Holyoke, MA 01040
f: 413-315-5317

SERVICE REQUEST

Date: ____________
Client Name: ____________________________DOB: ____________Age: _____ SSN: _________________
☐ Male or ☐ Female Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Address: ______________________________________City: _________________State:______Zip: _______
Phone #: _________________________Alternate # (& type): ____________________
May I leave a voice mail? ☐ No ☐ Yes If so, which number(s)? ________________________________
Emergency Contact Name: _____________________Relationship: ______________Phone #: ______________
Referred by: ____
What is happening in your life which resulted in this service request? ____________________________
____
____
____
Employment status: ☐ FT ☐PT ☐ Unemployed ☐ Student ☐ Retired ☐ Disabled
Custody status, if applicable: _______________________ Legal:________________Physical: _____________
Primary Care Physician (PCP): ________________________________PCP Phone #: ____________________
PCP Address: ____
Discharged from any inpatient service? ☐ No ☐ Yes (describe type, where, & when): ___________________
____
Have you ever received any mental health or substance abuse services? ☐ No ☐ Yes (describe type, where, & when. Use reverse side of page if necessary.):
____
____
____
____
Are you currently receiving any mental health or substance abuse services? ☐ No ☐ Yes (describe type, where, & when): ____
____
Do you drink any alcohol? ☐ No ☐ Yes Have you in the past? ☐ No ☐ Yes
Do you use any drugs? ☐ No ☐ Yes Have you in the past? ☐ No ☐ Yes
Are you currently prescribed any medications? ☐ No ☐ Yes (please list medications, dosage amount & times, and prescribers):
____
____
____
____
Any allergies? ☐ No ☐ Yes (to what?):____
Any current or ongoing health or pain issues? (please describe): ___________________________________
____
____

Responsible Party Information

Name of person who will pay for services or will be responsible for any amounts not covered by insurance:
____

If you have insurance please fill out below

Primary Insurance Coverage Information:

Name of Insured: __________________________________
Relationship to Client: ______________________________
Insurance Company: ________________________________
Insurance ID #: ____________________________________
Group ID #: _______________________________________

Other Info, if available:
Plan Code: ___________Member Suffix: _______Carrier Code: ________Policy #: ______________________
Address: __________________________City: ______________________State: __________ Zip: __________
Co-payment amount for counseling services (if known): _______________

Secondary Insurance Coverage Information (if any):

Name of Insured: ___________________________________
Relationship to Client: _______________________________
Insurance Company: ___________________________________
Insurance ID #: _____________________________________
Group ID #: ____

Other Info, if available:
Plan Code: ___________Member Suffix: _______Carrier Code: ________Policy #: ______________________
Address: __________________________City: ______________________State: __________ Zip: __________
Co-payment amount for counseling services (if known): _______________

FOR OFFICE USE ONLY (to be filled out by treatment provider) Sign/Date: _______________________
DIAGNOSTIC CODE(S):

1__________________________2_______________________3_____________________4________________

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GENERAL OFFICE POLICIES

Treatment Sessions & Payment

Counseling sessions are generally 50-minutes in length, although your initial appointment may be longer. If you are not using insurance, your session fee is due before the session; otherwise, your copay is due. Please note that deductibles may apply. I currently do not take debit or credit cards. Please bring the exact, correct amount if you are paying with cash. If any problem arises during the course of therapy regarding your ability to make timely payments, bring this to my attention.

Related Services

Occasionally, during the course of therapy, a need for ancillary services is identified. These are generally attended to during the course of your 50-minute treatment session, and are billed and paid for accordingly. Telephone conversations, report writing and reading, assistance with applications of any kind, consultation with other professionals, completing releases of information, generating and faxing correspondence, and so forth, will be charged at the same session/copay rate, unless indicated and agreed otherwise.

Cancellation

Since scheduling of an appointment involves the reservation of time specifically for you, a minimum of 24 hours' notice is required for rescheduling or canceling an appointment. More notice is appreciated for Monday appointments.

In order to provide me with the above notice, you will need to cancel via telephone. I do not accept e-mail cancellations, as I am not online consistently.

Since insurance companies do not reimburse for missed appointments, *unless we reach a different agreement, you will be charged a $25.00 cancellation fee, for sessions missed without 24 hours' notification.*

This fee may be waived or adjusted in cases involving emergencies, solely at my discretion.

I have read the above agreement and office policies and general information carefully. I understand them and agree to comply with them:

____

Signature of Client or Representative | Relationship (if not client) | Date

____

Printed Name | Date

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NOTICE OF PRIVACY PRACTICES

This notice describes how psychological and medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

It is my legal duty to safeguard your protected health information (PHI)

By law I am required to insure that your PHI is kept private. With some exceptions, I may not use or disclose more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made; however, I am always legally required to follow the privacy practices described in this notice.

I am required to provide you with this notice about my privacy procedures. This notice must explain when, why, and how I would use and/or disclose your PHI.

- “PHI” constitutes information created or noted by me that can be used to identify you. It contains data about your past, present, or future health or condition, the provision of health care services to you, or the payment for such health care
- “Use” of PHI means when I share, apply, utilize, examine, or analyze information within my practice.
- “Disclosure” applies to when I release, transfer, give, or otherwise reveal it to a third party outside my practice.

How I will use and disclose your PHI

I will use and disclose your PHI for many different reasons. Some of the uses or disclosures will require your prior written authorization; others, however, will not. Below you will find the different categories of my uses and disclosures, with some examples.

Uses and Disclosures Requiring Authorization

I may use or disclose PHI for treatment, payment, and health care operations. You may revoke an authorization to release information at any time.

- Treatment: When I provide, coordinate, or manage your health care and other services related to your health care I may need to disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are otherwise involved in your care. Example: If a psychiatrist or other prescriber is treating you, I may disclose your PHI in order to coordinate your care.
- Payment: To bill and collect payment for the treatment and services I provide you. Example: When I disclose your PHI to your insurance company to obtain reimbursement or to determine eligibility for coverage.
- Health care operations: These are activities which facilitate the efficient and correct operation of my practice and pertain to quality control, case management, care coordination, and business related matters. Example: Administrative personnel, accountants, auditors, and consultants are individuals to whom PHI may be disclosed. I could also provide your PHI to business associates, such as billing companies, claims processing companies, and copying services.

Uses and Disclosures with Neither Consent nor Authorization

I may use and/or disclose your PHI without your consent or authorization for the following reasons:

- Child Abuse – If I, in the ordinary course of my profession, have reasonable cause to suspect or believe that any child under the age of eighteen years (1) has been abused or neglected, (2) has had non-accidental physical injury, or injury which is at variance with the history given of such injury, inflicted upon such child, or (3) is placed at imminent risk of physical harm, then I must report this suspicion or belief to the appropriate authority.
- Adult and Domestic Abuse – If I know or in good faith suspect that an elderly individual or an individual who is disabled or incompetent has been abused, I may disclose the appropriate information.
- Health Oversight Activities – If a government agency is investigating my practice, I have to disclose some information.
- Judicial and Administrative Proceedings – There are some federal, state, or local laws which require me to disclose PHI. If you are involved in a lawsuit or legal proceedings and I receive a subpoena, discovery request, or other lawful process, I may have to release some of your PHI. I will only do so after trying to inform you of the request, consulting your lawyer, or trying to obtain a court order to protect the requested information. If you bring a lawsuit against me and disclosure is necessary or relevant to my defense, I may disclose the appropriate information.
- Serious Threat to Health or Safety – If I believe in good faith that there you are at risk of imminent personal injury to yourself or to other individuals or risk of imminent injury to the property of other individuals, I may disclose the appropriate information. I may also disclose PHI if it is necessary for you to be hospitalized for psychiatric care or to receive emergency care.
- Worker's Compensation – I may disclose PHI regarding you as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law, that provide benefits for work-related injuries or illness without regard to fault.

Patient's Rights Regarding PHI

- Right to Inspect and Copy - You have the right to see and/or get copies of information included in my mental health and billing records. This may be subject to certain limitations and fees. Your request must be in writing. You will receive a response from me within 30 days of my receiving your written request. Under certain circumstances, I may feel I must deny your request, but if I do, I will give you, in writing, the reasons for the denial, upon your request. I will also explain your right to have my denial reviewed. If you ask for copies of your PHI, you may be charged for the costs of copying and/or mailing, but only if you agree to the cost in advance.
- Right to Request Restrictions - You have the right to ask that I limit how I use and disclose your PHI. While I will consider your request, I am not legally bound to agree. If I do agree to your request, I will put those limits in writing and abide by them except in emergency situations. You do not have the right to limit the uses and disclosures that I am legally required or permitted to make.
- Right to Receive PHI by Alternative Means and Alternative Locations - It is your right to request and receive PHI by an alternate method (for example, you may ask that I not contact your work telephone number). It is also your right to ask that your PHI be sent to you at an alternate address (for example, receiving correspondence from my office at a different location). I am obliged to agree to your request providing that I can give you the PHI, in the format you requested, without undue inconvenience.

- Right to an Accounting - You are entitled to a list of disclosures of your PHI that I have made. Generally, records are kept of such disclosures. The list will not include uses or disclosures to which you have already consented, that is, those for treatment, payment, or health care operations, sent directly to you, or to your family; neither will the list include disclosures made for national security purposes, disclosures to corrections or law enforcement personnel, or disclosures made before April 15, 2003. After April 15, 2003, disclosure records will be held for 6 years.
- Right to Amend Your PHI - If you believe that information in your record is inaccurate or incomplete, you may request an amendment of the information. You must submit sufficient reason and information to support your request for amendment and the request must be in writing. I may deny your request, in writing, under certain circumstances. Upon your request, I will discuss with you the details of the amendment process and any reasons for denying a request.
- Right to a Copy - You have the right to get a paper or e-mail copy of this notice.
- Right to File a Complaint – If, in your opinion, I may have violated your privacy rights, or, if you object to a decision I made about access to your PHI, you are entitled to file a complaint with the Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W., Washington, D.C., 20201.

PRIVACY PRACTICES PERTAINING TO SUBSTANCE ABUSE RECORDS

The confidentiality of protected health information related to alcohol and drug abuse is protected by federal law and regulations. Violation of the applicable federal law and regulations is a crime, and may be reported to appropriate authorities.

In general I may not disclose any information about you unless you authorize the disclosure in writing. Specified below are exceptions to this general rule, and present situations where I may disclose information about you:

- If a court orders the disclosure
- In a medical emergency, to permit you to receive needed treatment
- For purposes of program evaluations, audits, or research
- If you commit a crime on the premises, or against any person that works on the premises, or, if you threaten to commit such a crime

Please note that I am required to disclose information about you if I suspect child abuse or neglect.

Except as stated in this section pertaining to substance abuse information, you have the same rights and protections with respect to your PHI as described in the entirety of this document.

Effective date of this notice: April 14, 2003.

I reserve the right to change the terms of this notice and my privacy policies at any time as permitted by law. Any changes will apply to PHI already on file with me. Before I make any important changes to my policies, I will send you a copy of the changes and I will post the new policy on my Web site http://www.lindabenoit.com