New England Sex Therapy, LLC

ONLINE THERAPY PATIENT INTAKE FORM

(Please talk to Jassy Casella Timberlake if you feel in any way uncomfortable with signing this paperwork. We can discuss the specifics of the information changes requested.)

Patient Name _____Home Phone _____

Street Address _____ Cell Phone_____

Mailing Address _____ Work Phone_____

City_____ Email_____

State_____ Zip Code_____ Date of Birth_____

May I call you at the above numbers? Y or N

May I leave a message at this email address? Y or N

Legal Sex: _____ Marital Status: S M D W

Do you identify as transgender? ____ Pronouns: _____

Primary Care Physician (PCP) _____ PCP Office Phone_____

PCP Address _____

Are you a full-time student? Y or N What school? _____

Are you seeing another therapist for mental health services? Y or N

PRIMARY RESPONSIBLE PARTY *(This is the person responsible for paying any balances).*

Name _____

Mailing Address_____

City _____ State _____ Zip Code _____

Phone_____

New England Sex Therapy, LLC

PATIENT CONSENT AND AUTHORIZATION

Consent to Treatment: _____Initials _____Initials

I hereby consent to receive mental health treatment from New England Sex Therapy, LLC (hereafter referred to as NEST.) I understand that my consent is voluntary. I also understand that I do not have to accept any treatment option NEST offers and that I may withdraw my consent at any time.

I accept that working toward change may involve experiencing difficult and intense feelings, some of which may be painful, in order to reach therapy goals. I understand that the changes I make will have an impact on my partner and on others around me. I accept that such changes can have both positive and negative effects and agree to clarify and evaluate potential effects of changes before undertaking them. *[This is especially true if I have dependent children.]*. On the other hand, therapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress.

I understand that online therapy is conducted remotely using a computer, Internet and webcam. I further acknowledge that while this is synchronous therapy, it is not conducted face-to-face. I also understand that an intake must be conducted, using video conferencing, to ensure that this kind of treatment is appropriate for treatment. I further confirm that I am a Massachusetts, Maine or Vermont resident, and agree to only conduct online therapy session while I am within the state of Massachusetts, Maine or Vermont.

While Online therapy has the benefit of being easy to access due to the lack of physical limitations, such as geography or time restrictions, it also carries with it other kinds of restrictions, such as possible technological limitations. I fully comprehend that maintaining quality of video and sound is dependent on factors such as software, hardware, Internet connection and speed, and any extraneous noise and lighting challenges. I under that there may be times when these issues may compromise my online therapy session, causing disruption or accidental termination of the session. I understand that my therapist will make every attempt to contact me via telephone at the number I supply in order to either continue the session via phone, or to reschedule for another time and date.

Online Therapy Sessions:

_____ Initials _____Initials

I understand in requesting treatment via online therapy, there are tenets to which I must agree:

1. Therapy will be conducted via a video platform chosen by NEST. Sessions will not be conducted by any other platform.
2. There are occasions when technological limitations cause disruption to online sessions. Internet connection and speed, power outages, hardware problems and issues with software can all negatively impact a therapist's ability to provide services.
3. Therapy sessions require an environment that can guarantee, as much as possible, freedom from disruption. No other person may be in the room during my online therapy session, and if there are other individuals present, this information should be disclosed to my therapist before the onset of treatment for that session so that all present may consent.
4. Due to the lack of visual cues and information during online therapy, misunderstandings occasionally occur.
5. I understand that seating and lighting should be established that allows for maximum visibility of both the therapist and myself.
6. I understand that any computer or camera used during these sessions must be placed on a stable and secure surface.
7. I agree to provide an alternate phone number in case of disruption during the online session.
8. I agree to provide my therapist with contact information in the unlikely event of an emergency during the course of the online session.
   Name of family member: _____ Phone number: (---) --- ----
9. I understand that the computer used for online therapy should have up to date antivirus protection.
10. I understand that online therapy sessions will not be recorded unless and until my written consent is given to my therapist.

Treatment Sessions/Cancellation Policy:

_____ Initials _____Initials

I understand that standard treatment sessions are 50 minutes in length, but that exceptions may occur.

If I am unable to keep an appointment, I agree to notify NEST **at least 24 hours in advance. I understand that I will be charged the full session rate of $170 for individual therapy and $200 for couples therapy for all sessions cancelled with less than 24- hour notice.** I also understand that this fee is not covered by insurance and that NSTA may waive this fee in cases involving emergencies, but that such waiver is solely at the discretion of NEST.

Couples Therapy and Release of Medical Records:

_____ Initials _____Initials

I understand in order for any therapy information or medical records to be released, **both** members of any couple must provide written authorization. If some individual sessions may help the process of couples therapy, what I say in those individual sessions will be considered to be a part of the medical record.

I also understand that information discussed in couples therapy is for therapeutic purposes and is not intended for use in any legal proceedings involving the couple. I agree not to subpoena my therapist to testify for or against either party or to provide records in a court action.

Confidentiality:

_____ Initials _____Initials

I understand that our communications are private and protected by law. Because of laws protecting confidentiality, in most situations my therapist cannot share information about our work without my permission. However, there are certain specific limits to confidentiality. I fully understand these limits below.

1. In order for NEST to function, my therapist may share some of my protected information for purposes such as scheduling and billing.

2. NEST uses TherapyNotes, an online Electronic Health Records system. As required by HIPAA, NEST has a formal business associate contract with this business, in which it promises to maintain the confidentiality of this data except as specifically allowed in the contract or otherwise required by law.

3. There may be times during our work when, in order to support progress toward my goals, my therapist will consult with a colleague or supervisor. My therapist will do this in a way that minimizes identifying information. All mental health professionals with whom my therapist consults are bound by the rules of confidentiality.

4. Generally, if I am involved in legal proceedings, my therapist cannot provide any information about our work without my permission. There are exceptions and, if I anticipate being involved in litigation, I should consult my attorney to determine whether a court could order my therapist to disclose information.

5. If I file a complaint or lawsuit against my therapist, my therapist may disclose relevant information pertaining to me in order to defend himself/herself.

6. If, in the course of our work, my therapist has reasonable cause to believe that any child under the age of 18 is being (or has been) physically or emotionally harmed in any way (either because of abuse--including sexual abuse--or neglect) the law REQUIRES my therapist to file a report with the Massachusetts Department of Children and Families. My therapist will inform me if he/she finds that he/she must file a report.

7. Similarly, if my therapist has reasonable cause to believe that an elderly person (age 59 or older) or a handicapped person of any age is (or has been) suffering from abuse, the law REQUIRES that my therapist file a report with the appropriate authorities.

8. Finally, if I let my therapist know that I intend to harm myself or intend to harm another person and my therapist believes the risk is real, my therapist may be REQUIRED to break confidentiality by contacting the police, alerting the intended victim, contacting a family member, or seeking my hospitalization without my consent.

Communication and Availability:

_____ Initials _____Initials

Due to my therapist's work schedule, my therapist is often not immediately available by telephone. When my therapist is unavailable, an automated voice mail answers her telephone. My therapist will make every effort to return my call on the same day I make it, with the exception of weekends and holidays. If I will be difficult to reach, I will inform my therapist of some times when I will be available. In a life-threatening emergency, I will call 911 or go to the nearest Emergency Room.

I understand that email is not a secure medium for communication and my therapist's preference is that I contact her by phone. However, if I choose to contact my therapist using email, I am doing so with the full understanding that my therapist cannot guarantee the safety and security of that communication, despite NEST taking all possible action to protect my privacy. I also acknowledge that email occasionally disappears or is delayed and that my therapist may never receive an email that I sent.

Financial Obligation:

_____ Initials _____Initials

I understand that I am responsible for full payment of all fees for services provided by NEST regardless of whether there is insurance coverage. I understand that unless prior arrangements are made, I agree to pay any self-pay fee amounts at the end of each session. I also understand that checks returned for insufficient funds will result in a $25.00 processing fee.

Missed Appointments:

_____ Initials _____Initials

NEST recognizes that situations come up when I might need to miss more than one appointment during the course of a month. NEST is only able to hold my customary appointment time as a courtesy for up to 4 weeks.

If I miss more than one appointment within a month for any reason, I will be charged a $170 fee (per week) as an individual client, or $200 for a couple, so that my appointment time can be maintained.

Note: This fee will be charged regardless of advanced notice duration. NEST cannot offer this benefit for more than 4 weeks.

I understand that I will need to pay for the reserved appointments in advance, and that not doing so will mean that my normal appointment time cannot be guaranteed.

Assignment of Benefits and Release of Information:

_____ Initials _____Initials

I authorize the release of any medical information needed to determine benefits, including medical, psychiatric and/or substance abuse (drug or alcohol) information. This authorization shall remain in effect until written notice is given by me revoking this authorization. I certify that the information given is correct. I agree to pay any balance due in full no later than 30 days of statement, unless other arrangements have been made in advance.

ACKNOWLEDGEMENT

My initials above and signature below acknowledge that I understand and accept the terms and conditions of this authorization and agreement. If the patient is a minor child, an appropriate guardian must sign below. Such signature acknowledges that this authorization and agreement applies to the minor child.

Signature:_____**Date:**_____

Signature:_____**Date:**_____

Relationship to patient if signed by parent/guardian:_____

Social Media Policy

This document outlines New England Sex Therapy, LLC's (NEST) policies related to use of Social Media. Please read it to understand how you can expect your therapist to respond to various interactions that may occur between you online. If you have any questions about anything in this document, you are encouraged to bring them up when you next meet with your therapist. As new technology develops and the Internet changes, there may be times when this policy will need to be updated. If this happens you will be notified of this policy change by your therapist.

Friending

Your therapist at NEST will not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc). Adding clients as friends or contacts on these sites can compromise your confidentiality and respective privacy for both clients and clinicians. It may also blur the boundaries of your therapeutic relationship. If you have questions about this, please bring them up with your therapist. You are welcome to view NEST's Professional Facebook page if you wish to have access to articles and helpful information.

Please note that your therapist will not follow you back on any social media platform. Doing so is considered an ethical violation. Casual viewing of clients' online content outside of the therapy hour can create confusion in regard to whether it's being done as a part of your treatment or to satisfy a clinician's personal curiosity. In addition, viewing your online activities without your consent and without an explicit arrangement towards a specific purpose could potentially have a negative influence on your working relationship with your therapist. If there are things from your online life that you wish to share with your therapist, please bring them into your sessions where you can explore them together during the therapy hour.

Interacting

Please do not use SMS (mobile phone text messaging) or messaging on Social Networking sites such as Twitter, Facebook, Messenger or LinkedIn to contact your therapist. These sites are not secure. For the same reason, please do not use Wall postings, @replies, or other means of engaging with your therapist in public online if you have an already established client/therapist relationship. Engaging with your therapist in this way could compromise your confidentiality. It may also create the possibility that these exchanges become a part of your legal medical record and will need to be documented and archived in your chart.

Use of Search Engines

It is NOT a regular part of NEST's practice to search for clients on Google or Facebook or other search engines. Extremely rare exceptions may be made during times of crisis. If your therapist has a reason to suspect that you are in danger and you have not been in touch with them via the usual means (coming to appointments, phone, or email) there might be an

instance in which using a search engine (to find you, find someone close to you, or to check on your recent status updates) becomes necessary as part of ensuring your welfare. These are unusual situations and if your therapist ever resorts to such means, they will fully document it and discuss it with you when you next meet.

Google Reader

NEST does not follow current or former clients on Google Reader and they do not use Google Reader to share articles. If there are things you want to share with your therapist that you feel are relevant to your treatment whether they are news items or things you have created, you are encouraged to bring these items of interest into your sessions.

Business Review Sites

You may find NEST listed on sites such as Yelp, Healthgrades, Yahoo Local, Bing, or other places which list businesses. Some of these sites include forums in which users rate their providers and add reviews. Many of these sites comb search engines for business listings and automatically add listings regardless of whether the business has added itself to the site. If you should find NEST's listing on any of these sites, please know that the listing is not a request for a testimonial, rating, or endorsement from you as NEST's client.

Of course, you have a right to express yourself on any site you wish. But due to confidentiality, your therapist at NEST cannot respond to any review on any of these sites whether it is positive or negative. You are urged to take your own privacy as seriously as NEST's own commitment of confidentiality to you. You should also be aware that if you are using these sites to communicate indirectly with your therapist at NEST, there is a good possibility that they may never see your posting. If you do choose to write something on a business review site, please keep in mind that you may be sharing personally revealing information in a public forum. NEST encourages you to create a pseudonym that is not linked to your regular email address or friend networks for your own privacy and protection.

By signing below, I am indicating that I have read this document, understand my rights as a client, and accept the responsibility as stated.

Client Name: _____

Printed name: _____

Date: __/__/_____

New England Sex Therapy, LLC

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.

Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

- ”PHI” refers to information in your health record that could identify you.
- “Treatment, Payment, and Health Care Operations” -Treatment is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist. -Payment is when I obtain reimbursement for your health care. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage. -Health Care Operations are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- “Use” applies only to activities within my office, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- “Disclosure” applies to activities outside of my office, such as releasing, transferring, or providing access to information about you to other parties.

After you have read this notice you will be asked to sign a form indicating receipt of this notice as well as a separate Consent form to allow me to use and share your PHI. In almost all cases I intend to use your PHI here in my office or share your PHI with other people or organizations to provide **treatment** to you, arrange for **payment** for my services, or health care **operations**.

Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An “authorization” is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment, or health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before:

- Releasing your Psychotherapy Notes. “Psychotherapy Notes” are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection.

- Use or disclosure of your protected health information for marketing purposes.

You may revoke all such authorization (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- *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 nonaccidental 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 serious 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.

i. If you are involved in a lawsuit or legal proceeding 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.

ii. If you bring a lawsuit against me and disclosure is necessary or relevant to a defense, I may disclose the appropriate information.

- *Serious Threat to Health or Safety* - If I believe in good faith that there is 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.

- *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 and Therapist's Duties

Patient's Rights:

- *Right to Request Restrictions* – You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.

- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address.)

- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI and psychotherapy notes in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.

- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described above in this Notice). On your request, I will discuss with you the details of the accounting process.

- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

- *Right to Restrict Disclosures When You Have Paid for Your Care Out-of-Pocket*. You have the right to restrict certain disclosures of PHI to a health plan when you pay out-of-pocket in full for my services.

- *Right to Be Notified if There is a Breach of Your Unsecured PHI*. You have the right to be notified if: (a) there is a breach (a use or disclosure of your PHI in violation of the HIPAA Privacy Rule) involving your PHI; (b) that PHI has not been encrypted to government standards; and (c) my risk assessment fails to determine that there is a low probability that your PHI has been compromised.

- **Therapist's Duties:**

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will notify you in person, via mail, or via another method agree to in advance.

Questions and Complaints If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact me at 413.587-0095 for additional information. If you believe that your privacy rights have been violated and wish to file a complaint with me, you may send your written complaint to Jassy Casella Timberlake. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. Our Security Officer can provide you with the appropriate address upon request. You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

Other Uses of PHI in Healthcare

• Business Associates - There are some jobs I hire other businesses to do for me. In the law, they are called Business Associates. Examples may include a copy service to make copies of your health records or a billing service to print, mail, and follow-up on my insurance claims for reimbursement, to mail patient bills, and/or to contact your insurance company regarding benefits, eligibility, and authorization. These business associates need to receive some of your PHI to perform their jobs properly. To protect your privacy they have agreed in a signed contract to safeguard your information.

The effective date of this notice is April 14, 2003.

New England Sex Therapy, LLC

NOTICE OF PRIVACY PRACTICES

PATIENT NAME _____

PATIENT DATE OF BIRTH_____

THE SIGNATURE BELOW INDICATES THAT I HAVE RECEIVED A COPY OF THE NOTICE OF PRIVACY PRACTICES FROM NSTA:

SIGNATURE OF PATIENT OR GUARDIAN _____**DATE** _____

GUARDIAN'S NAME (*Please print)*_____

RELATIONSHIP TO PATIENT_____