MAVERICK
PSYCHOTHERAPY GROUP

Adult Intake Packet

Please read the following information regarding our policies. By signing this form, you agree that you have read and agree to these policies.

1. **Insurance, Payment and Claims Authorization Policy**
2. **Cancellation Policy**
3. **Electronic Communication Policy**

Please read the Consent Forms that follow. By signing this form, you give permission for treatment from our clinicians.

1. **Telehealth Consent**
2. **Informed Consent to Individual Psychotherapy**

In addition to the policies that follow, you have been sent a Notice of our Privacy Practices. By signing this form, you acknowledge that you have received this Notice. It is also available on our website.

By signing this form, you acknowledge that you have been informed that psychiatry services may be available to you as a client of Maverick Psychotherapy Group.

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Insurance, Payment and Claims Authorization Policy

Payment and Insurance Policy: Our office will be glad to complete and submit any and all insurance forms, but payment and follow-up are the responsibility of the contract holder. Payment and copayments are due at the time services are rendered. It is the obligation of the client to make payment and not that of the insurance carrier unless otherwise explicitly stated by a provider agreement signed in this office.

Claims Authorization: "I hereby authorize the release of any medical or other information necessary to process this claim. If my coverage is under a Group contract held by an employer, an association, a trust fund, a union, or similar entity, this authorization also permits disclosure to them for the purposes of utilization, review or audit. This authorization shall become effective immediately upon execution and shall remain in effect for the duration of any claim or term of coverage with the insurer, including a reasonable time thereafter, until its final consummation."

***It is the client's responsibility to keep abreast of changes in their own insurance coverage. If insurance coverage lapses resulting in unpaid sessions, the client is responsible for payment. In the event that a client's insurance lapses, it may result in several weeks of unpaid visits before it comes to our attention. Therefore, the balance due may reflect several weeks of sessions.**

***MPG does not accept straight Medicaid. Sessions that occur during a period of coverage with straight medicaid will therefore become the client's responsibility.**

***Copays and Deductibles: Many insurance companies have waived the copays and deductibles due to the Covid-19 crisis. We will do our best to inform you as soon as we find out that they have stopped waiving these charges. Please be aware however, that when the charges are reinstated, they will begin to accrue in your account and you will be responsible for these.**

Cancellation Policy

Cancellation Policy: Therapy is a commitment between a clinician and a client. When a client and clinician begin treatment, they are making a commitment to a therapeutic process and also to a specific and reserved time. If you miss an appointment or are unable to provide at least 24 hours notice when you cancel, you may be charged a $70.00 cancellation fee. Insurance does not cover missed appointment fees.

Electronic Communication Policy

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We try our best to ensure the privacy and confidentiality of email and text messaging, however, this is not something we can guarantee. We ask that text messaging only be used for scheduling purposes unless otherwise specified by your clinician. Our appointment system will send you an appointment reminder via email and you will have the option to opt out. This email is not sent by your individual clinician.

Telehealth Consent Introduction

Telehealth is the delivery of healthcare services using interactive audio and visual electronic systems between a provider and a patient that are not in the same physical location. The interactive electronic systems used in Telehealth incorporate network and software security protocols to protect the confidentiality of patient information and audio and visual data. These protocols include measures to safeguard the data and to aid in protecting against intentional or unintentional corruption.

Potential Benefits

• Increased accessibility to mental healthcare.

• Patient convenience.

Potential Risks

As with any medical procedure, there may be potential risks associated with the use of telehealth.. These risks include, but may not be limited to:

• Delays in medical evaluation and treatment may occur due to deficiencies or failures of the equipment. Every effort will be made to overcome technical difficulties.

•While every effort is made to ensure the confidentiality of tele-communications security protocols can fail, causing a breach of privacy of confidential health information.

Alternatives to the Use of Telehealth

• Traditional face-to-face sessions in your provider's office.

Patient's Rights

• I understand that the laws that protect the privacy and confidentiality of medical information also apply to Telehealth.

• I have the right to withhold or withdraw my consent to the use of Telehealth during the course of my care at any time. I understand that my withdrawal of consent will not affect any future care or treatment.

• I have the right to inspect all medical information that includes the Telehealth visit. I may obtain copies of this medical record information for a reasonable fee.

• I understand that my provider has the right to withhold or withdraw consent for the use of Telehealth during the course of my care at any time.

• I understand that the laws that protect the privacy and confidentiality of medical information also apply to Telehealth.

• I understand that the rules and regulations that apply to the provision of healthcare services in the State of New York also apply to Telehealth.

Patient's Responsibilities

• I will not record any Telehealth sessions without written consent from my provider. I understand that my provider will not record any of our Telehealth sessions without my written consent.

• I will inform my provider if any other person can hear or see any part of our session before the session begins. The provider will inform me if any other person can hear or see any part of our session before the session begins.

• I understand that I, not my provider, am responsible for the configuration of any electronic equipment used on my computer that is used for Telehealth. I understand that it is my responsibility to ensure the proper functioning of all electronic equipment before my session begins.

•I understand that I must be present in the State of New York to be eligible for Telehealth services from my provider.

•I understand that in the case of an emergency I must contact my local emergency services by calling 911 from my own location.

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Informed Consent to Individual Psychotherapy

This form documents that I give my consent to the psychotherapist at Maverick Psychotherapy Group, to provide psychotherapeutic treatment to me.

While I expect benefits from this treatment, I fully understand that no particular outcome can be guaranteed. I understand that I am free to discontinue treatment at any time but that it would be best to discuss with the psychotherapist any plans to end therapy before doing so. Our discussion about therapy has included the psychotherapist's evaluation and diagnostic formulation of my problems, the method of treatment, goals and length of treatment, and information about record-keeping. I have been informed about and understand the extent of treatment, its foreseeable benefits and risks, and possible alternative methods of treatment. I understand that therapy can sometimes cause upsetting feelings to emerge, and that I may feel worse temporarily before feeling better, and that I may experience distress caused by changes I may decide to make in my life as a result of therapy.

I understand that the psychotherapist cannot provide emergency services. The psychotherapist has told me whom to call if an emergency arises and the psychotherapist is unavailable. In any case, I understand that in any emergency, I may call 911 or go to the nearest hospital emergency room.

I have received the HIPAA Notice of Privacy Practices from the psychotherapist which is also available on the Maverick Psychotherapy Group website (www.maverickpsychotherapygroup.com). I understand that information about psychotherapy is almost always kept confidential by the psychotherapist and not revealed to others unless I give my consent. There are a few exceptions as noted in the HIPAA Notice of Privacy Practices. Details about those exceptions follow:

1. The psychotherapist is required by law to report suspected child abuse or neglect to the proper authorities.

2. If I tell the psychotherapist that I intend to harm another person, the psychotherapist must try to protect that person, including by telling the police or the person or other health care providers. Similarly, if I threaten to harm myself, or my life or health is in any immediate danger, the psychotherapist will try to protect me, including by telling others such as my relatives or the police or other health care providers, who can assist in protecting or assisting me.

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3. If I am involved in certain court proceedings the psychotherapist may be required by law to reveal information about my treatment. These situations include child custody disputes, cases where a therapy patient's psychological condition is an issue, lawsuits or formal complaints against the psychotherapist, civil commitment hearings, and court-related treatment.

4. If my health insurance or managed care plan will be reimbursing me or paying the psychotherapist directly, they will require that I waive confidentiality and that the psychotherapist give them information about my treatment.

5. The psychotherapist may consult with other psychotherapists about my treatment, but in doing so will not reveal my name or other information that would identify me unless specific consent to do so is obtained. Further, when the psychotherapist is away or unavailable, another psychotherapist might answer calls and will need to have access to information about my treatment.

6. Some of our psychotherapists are supervised by senior clinicians in the practice who have access to their supervisees notes. If you are being seen by a supervised psychotherapist, your information will be accessible to your therapist's supervisor.

7. If my account with the psychotherapist becomes overdue and I do not pay the amount due or work out a payment plan, the psychotherapist will reveal a limited amount of information about my treatment in taking legal measures to be paid. This information will include my name, social security number, address, dates and type of treatment and the amount due.

In all of the situations described above, I understand that the psychotherapist will try to discuss the situation with me, or notify me, before any confidential information is revealed, and will reveal only the least amount of information that is necessary.

If I am participating in a managed care plan, I have discussed with the psychotherapist the plan's limits, if any, on the number of therapy sessions. I have discussed with the psychotherapist my options for continuation of treatment when my managed care benefits end.

I understand that I have a right to ask the psychotherapist about the psychotherapist's training and qualifications and about where to file complaints about the psychotherapist's professional conduct.

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If you are completing this Intake Form on paper or through email, please sign here acknowledging that you have read and agree to all of the policies detailed above.

Print Name: _____

Signature: _____

Date:_____