TAK Center for Mental Health
1069 Central Street, Leominster MA 01453
Telephone: 978-728-4957
Fax: 978-798-1366
takcmh.com

PSYCHIATRY & THERAPY NEW PATIENT FORM

We would like to take this opportunity to welcome you to our practice and to thank you for choosing TAK Center for Mental Health for your behavioral health needs.

The goal of these forms is to gather relevant information prior to your appointment, so our providers can review this beforehand and offer customized care during the visit. Upon completion of this paperwork, you may return via DocuSign, mail, email, fax, or come to the office to drop it off. Our team will call to schedule your first appointment once this packet has been completed in its entirety within 48 hours. At times, there may be delays due to unforeseen circumstances, so if you do not hear back from our team, we recommend reaching out to us to expedite the process.

We believe that the foundation to a healthy provider and patient relationship revolves around trust, respect, and communication. As such, a week prior to being seen, we will call to confirm your appointment. It is essential that we receive a confirmation, if we are unable to reach you multiple times prior to your appointment, your appointment may be cancelled to fill in another patient on our wait-list. Please contact us if you miss a call from our clinic so we can keep your files updated. As there is a strong need for behavioral health services and we are reserving an hour slot for your new patient visit, we may elect a $150 rebooking charge if you cancel within 24 hours of your appointment time or you "no-show" your first new patient appointment. This fee would be due before we are able to reschedule your missed appointment.

Prior to your first appointment, please confirm coverage with your health insurance company to verify your benefits and eligibility. They will be able to assist you with what to expect coverage wise, and if there is any financial responsibility (copayment, deductible, co-insurance, etc). When calling your insurance, please advise them of which clinician you are seeing, and ask them to confirm coverage and benefits. Our clinic checks to confirm your insurance is active prior to your appointment, and submits the claim to your insurance, so we encourage you to reach out to your insurance beforehand to understand how your specific benefits work.

Please be advised that we are an outpatient behavioral health clinic, and appointments are booked ahead of time; for any urgent needs, we will try our best to service you, however we cannot guarantee any same-day appointments or walk-in appointments. For any medical or psychiatric emergency, please dial 9-1-1 or go to your closest emergency room.

Our office is open Monday to Friday, with operating hours from 8:00AM – 5:30PM Monday to Thursday, and 8:00AM to 4:30PM on Fridays. We are closed during federal holidays. If you have any questions or need help filling out this form, you may reach us via phone: 978-728-4957, email: takcmhinfo@takmedgroup.com, or fax: 978-798-1366.

We know how important this visit is to you, and we once again thank you for choosing TAK Center for Mental Health. We look forward to working with you on your journey to well-being and health.

Sincerely,
Your team at TAK Center for Mental Health

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GENERAL OFFICE POLICY AGREEMENT

APPOINTMENTS:

It is critical to keep your scheduled appointments, as it effects your care, operations of the office, and patients who could have used the slot. We understand situations happen where you need to move your appointment, we ask that you kindly call the office at least 24 hours in advance. Any patient who arrives 10 minutes late for their appointment will only be seen if the schedule allows, this is up to the discretion of the clinician. If the appointment needs to be rescheduled, this will be considered a same-day cancellation.

A pattern of same-day cancellations and no-shows may be subject to fees and/or potential termination from the practice. The first established same-day cancellation or no-show within a calendar year may result in a $100 charge, second time may result in a $150 charge. Any additional times may result in discharge from the practice. One-time emergencies will be considered. For urgent issues, our office will try to make any same-day accommodations, however we cannot guarantee an appointment. For emergencies, please contact your nearest emergency department or contact 9-1-1.

SUPERVISION:

Our directors of psychotherapy services, Tamara Perini LICSW and Karen Sullivan LICSW, may be supervising other therapists within the practice, in which treatment plans, case strategies, and other important topics are discussed to help improve performance and quality. There may be instances where your supervised therapist is not independently credentialed with your insurance, and claims may be submitted under the in-network supervising clinician if appropriate. All client information will be handled with the utmost care and confidentiality in accordance with HIPAA laws.

PAYMENTS AND FEES:

Our office accepts major credit cards, checks, and HSA/FSA accounts for your convenience. Due to the COVID-19 pandemic, we are no longer accepting cash. Co-payments are due at the time of the appointment and any denied claims from your health insurance company will be the patient responsibility. Any patient responsibilities are due to your health insurance coverage and benefits; it is recommended to contact your insurance prior to contacting our office to review any bills. If you are experiencing financial difficulties, we may set up a payment plan for any cost-share responsibilities.

INSURANCE:

TAK Center for Mental Health accepts most insurance health policies, however it is the patient's responsibility to confirm coverage, eligibility, and benefits. If your clinician is not showing up as in-network with your insurance, please confirm if the supervising directors (Tamara Perini LICSW or Karen Sullivan LICSW) are participating with the insurance. If changing insurance carriers or to update your insurance information, please notify our office as soon as possible. If you are self-paying, payment is due at the time of booking or prior to your appointment.

CONFIDENTIALITY:

The session content and all relevant materials to the client's treatment will be held confidential unless the client requests in writing to have all or portions of such content released to specific individuals or parties. However, there are limitations to confidentiality such as in a legal or court proceeding, the release of patient information may be mandated by court order, and in instances where a patient is a threat to serious harm to themselves or someone else, or suspicion that a patient is a perpetrator or observer of physical, emotional, or sexual abuse of children, elderly, or disabled individuals.

Patient Name: _____ **Date of birth:** _____

Patient/Representative Signature: _____ **Date:** _____

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AUTHORIZATION/REQUEST FOR RELEASE of BEHAVORIAL HEALTH RECORD

(Also known as Protected Health Information)

Date: / /
Patient Name _____ Date of Birth _____

Psychotherapy Provider Information:
Karen Sullivan, LICSW Tamara Perini, LICSW Deborah Parsons, LMHC Michelle Chouinard, LCSW

Psychiatric Medication Management Provider Information:
Dr. Ramteen Rezai Dr. Carlin Lucky Meagan Dembitzky, N.P. Michelle VivoAmore, N.P.

I, (or on behalf of) _____ give permission to the providers listed above at TAK Center for Mental Health to exchange information about my medical and behavioral health internally amongst each other for applicable coordination of care and supervisory purposes.

In addition:
I authorize the exchange of information about any substance or alcohol abuse in my medical records.
[ ] Yes [ ] No

I authorize the exchange of information about any HIV blood tests results or HIV- or AIDS- related care in my records:
[ ] Yes [ ] No

1. I understand that, unless withdrawn, this authorization will expire 1 year from the date of signature. A photocopy of this form will be considered as valid as the original.
2. I understand that I may revoke this authorization at any time by notifying TAK Center for Mental Health at the address indicated above, in writing, and this authorization will cease to be effective on the date notified unless the information has already been released.
3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations. However, other state or federal law may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information and mental health information.
4. I hereby release all parties stated herewith from any liability resulting from the release of this information.

By signing below, I acknowledge that I have read and understand this Authorization.

Signature of Patient: _____ Date: _____
OR
Signature of Authorized Representative: _____ Name, Relationship, Date: _____

Refusal to Release Information
I do not consent to release the information as described above. However, I understand that if I do not allow my providers to exchange information about me, their ability to fully coordinate my care may be limited. I understand that in an emergency situation my providers may exchange information as medically necessary.

Signature of Patient/Representative: _____ Date: _____

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NEW PATIENT INTAKE QUESTIONNAIRE

Date: / /
Patient Name _____ Date of Birth _____

Who were you referred by? _____

Briefly describe the reason to seek therapy services:

_____
_____
_____
_____

List some goals that you hope to attain:

_____

_____

_____

In the past month:

Have you wished you were dead or wished you could go to sleep and not wake up?	☐ Yes	☐ No
Have you had any thoughts of killing yourself?	☐ Yes	☐ No
Have you been thinking about or planning on how you might kill yourself?	☐ Yes	☐ No
Have you had any intention of acting on your thoughts or carrying out your plan?	☐ Yes	☐ No

In the past (anytime):

Have you ever attempted to kill yourself?	☐ Yes	☐ No

If yes, how many times and how long ago? _____

In the past month:

Have you ever purposely hurt yourself? (cutting, burning, hitting, etc)	☐ Yes	☐ No

In the past (anytime):

Have you ever had thoughts or fantasies about harming other people?	☐ Yes	☐ No
Have you ever been violent towards other people?	☐ Yes	☐ No
Do you currently have access to a gun?	☐ Yes	☐ No

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HIPAA & CONSENT FORM

Patient's last name:	**First:**	**Middle Initial:**	**Marital status (circle one):** Single / Mar / Div / Sep / Wid
Former name (if applicable):	**Birth date:** / /	**Age:**	**Sex:** ❑ M ❑ F
Street address:		**Home phone no.:** ( )	**Cell phone no.:** ( )
P.O. box:	**City:**	**State:**	**ZIP Code:**

Race (check all that apply): ❑ American Indian or Alaska Native ❑ Asian ❑ Native Hawaiian or Other Pacific Islander ❑ Black or African American ❑ White ❑ Hispanic ❑ Other Race	**Ethnicity (check one):**	❑ Hispanic or Latino ❑ Not Hispanic or Latino
Social Security No.: _____ - _____ - _____	**E-mail Address:**	**Preferred Pharmacy/Location:**

By signing below, I acknowledge the following:

- I give TCMH (TAK Center for Mental Health) consent to access my prescription history, including all past prescribed medication, in order to verify future prescription refills.
- I give TCMH consent to bill my insurance company for any fees related to services provided by their staff, perform reasonable and necessary medical examinations, testing and treatment at the discretion of its healthcare professionals based on their clinical judgment of my condition.
- I give TCMH consent to bill me directly for any charges denied by my insurance company, and for any charges incurred in the event of lack of insurance coverage at the time of care.
- I understand that TCMH is not responsible for any bills incurred by me for testing, imaging, or services provided by outside facilities, including those services ordered by their staff.
- I give TCMH consent to call, text, and/or email an appointment reminder to the phone number listed above. I understand that there may be a voicemail left for me at this phone number.
- I acknowledge that I have been given access to TCMH's Notice of Privacy Practices.
- I authorize TCMH to discuss my health information with the following person(s):

Name	Telephone #	Relation

❑ Self Only: *If checked, TCMH will not release your information to anyone except as outlined in our Notice of Privacy Practices. Please initial* _____

I release TAK Center for Mental Health (TCMH) from all responsibility and liability that may arise from this authorization. I may withdraw this authorization at any time by giving written notification to TCMH, provided that I do so in writing and to the extent that we have already disclosed the information in reliance on this authorization.

_____ _____
Patient Signature (*or Guardian if patient is under the age of 18*) Date

_____ _____
Witness Signature Date