KERZNER
ASSOCIATES, P.C.

PSYCHOLOGICAL SERVICES

30 Mechanic Street • Foxboro, MA 02035 • (508) 543 2133 • www.kerznerassociates.net

## PATIENT:

Name _____ DOB _____

Address _____ Referred By_____

City_____ Zip Code _____

Home Phone _____ Gender_____

Cell Phone _____ SS#_____

Work Phone _____

Email Address _____

Primary Care Physician _____

Emergency Contact _____Phone # _____

## INSURANCE POLICY INFORMATION:

Policyholder Name _____ Relationship to Patient _____

Address _____ SS#_____

City_____ DOB _____

Home Phone _____

Cell Phone _____Work Phone _____

Primary Insurance Company _____

Subscriber ID#_____Ins. Co. Phone_____

Employer _____

Deductible: _____Deductible Met? _____

Copay Amount _____

Secondary Ins. Co. _____Subscriber for 2nd Ins _____

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OFFICE USE ONLY

DX A1 _____ DX A2 _____

DATE _____ TX _____

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# Credit Card Information

I authorize Kerzner Associates, P.C. to keep my credit card information securely on file. My credit card can be used for payment under the conditions I have initialed below:

_____ (initials) to cover all **copays**, **co-insurance** charges and/or applicable **deductible** amounts incurred at the time of each visit

_____ (initials) to cover any **missed appointment / late cancellation** fees`

_____ (initials) for **any balances** due for over 30 days

_____ (initials) to **settle any balances** due upon termination of treatment

_____ (initials) to **receive e-mail receipt** of transaction.
**E-mail address:** _____

I can revoke this authorization at any time by submitting a request in writing to my clinician and/or Kerzner Associates administrative staff.

_____
Patient Name

_____
Cardholder Name (if different)

_____
Cardholder's Signature

_____
Card Number

_____ _____
Expiration Date Security Code **Please circle:** Credit Debit HSA FSA

_____ _____
Zip Code Date Signed

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# ***PATIENT SERVICES AGREEMENT***

I have been given a copy of, read, and agree to the terms and conditions as stated in the Kerzner Associates Patient Services Information document. I have been offered/given a copy of our Policies and Practices To Protect the Privacy of Your Health Information. ("Massachusetts Notice Form")

I understand and consent to Kerzner Associates submitting necessary information to my insurance company in order to either be reimbursed or to get authorization for treatment. I have read and understand Kerzner Associates' policy which states that services may be withheld if I have a past due balance, and that Kerzner Associates has a **zero balance policy.**

By signing below, I understand, agree to, and identify myself as the responsible party for all fees not covered by health insurance, as outlined in the Patient Services Information document. If you are between the ages of 18 and 26 and are not the policyholder for your insurance coverage, your signature below authorizes us to communicate with the policyholder.

When you sign this page, it represents an agreement between you and Kerzner Associates. You may cancel this agreement at any time in writing. That cancellation will be binding on Kerzner Associates unless we have taken action in reliance on it; for example, if there are obligations imposed on your clinician by your health insurer in order to support claims made under your policy; or if you have not satisfied any financial obligation you have incurred.

By signing below, I agree to give my clinician at Kerzner Associates, P.C. permission to communicate with my Primary Care Physician for the sake of coordinating care.

_____By initialing, I authorize Kerzner Associates, P.C. to send a thank-you note to the person/ agency who referred me. This would not include any clinical information.
*Referral Source:* _____

*Patient's Name (Print Name):* _____

*Responsible Party Signature:* _____*Date*_____

- *Responsible Party (Print Name):* _____
- *Relationship to Patient:* _____
- *Responsible Party's Address:* _____
- *Responsible Party's Home Phone:* _____*Cell Phone:* _____

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# PATIENT E-MAIL INFORMED CONSENT FORM

Kerzner Associates, P.C. will use all reasonable means to protect the security and confidentiality of e-mail information sent and received. The transmission of client information by e-mail has a number of risks that patients and their clinicians should consider before using e-mail to communicate. These include, but are not limited to the following:

- *E-mail can be circulated, forwarded and stored in numerous paper and electronic files.*
- *E-mail can be immediately broadcast worldwide and be received by unintended recipients.*
- *Senders can easily type the wrong e-mail address or phone number.*
- *E-mail is easier to falsify than handwritten or signed documents.*
- *Backup copies of e-mails may exist even after the sender or the recipient has deleted their copy.*
- *Employers/online services have a right to archive and inspect e-mails transmitted through their systems.*
- *E-mail can be intercepted, altered, forwarded, or used without authorization or detection.*
- *E-mail can be used to introduce viruses into computer systems.*
- *E-mail can be used as evidence in court.*

The following guidelines should be followed when conducting e-mail communication with your clinician at Kerzner Associates, P.C. :

- *E-mail should not be used for emergencies or other time-sensitive matters.*
- *We advise that you not include clinical information in an e-mail.*
- *Your clinician will try to read and respond promptly to e-mail from you; however, we cannot guarantee that any particular e-mail will be read and responded to within any particular period of time. E-mails will not be responded to during a clinician's time off.*
- *If you have sent your clinician an e-mail and you have not received a response within a reasonable time period, please understand that it is your responsibility to follow up, to determine whether the intended recipient received the e-mail and when the recipient will respond.*
- *All e-mail messages to or from you, about your treatment, including scheduling issues, will be made part of your clinical record.*
- *We will not forward e-mails to independent third parties without your written permission, except as authorized or required by law.*
- *Please inform your clinician of any types of information that you do not want communicated via e-mail.*
- *Please understand that it is your responsibility to protect access to your e-mail account.*

***Patient's Name (Print Name):*** _____

***Responsible Party (Print Name):*** _____

***Responsible Party Signature:*** _____

***Date:*** _____

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# INFORMED CONSENT FOR TELEHEALTH

**Benefits and Risks of Telehealth**

Telehealth refers to providing psychotherapy services remotely using telecommunications technologies, such as video conferencing. One of the benefits of Telehealth is that the client and clinician can engage in services without being in the same physical location. This can be helpful in ensuring continuity of care if unable to meet in person. Telehealth, however, requires technical competence on both our parts to be helpful. Although there are benefits of Telehealth, there are some differences between in-person psychotherapy and Telehealth, as well as some risks. For example:

- Risks to confidentiality. Because Telehealth sessions take place outside of the therapist's private office, there is potential for other people to overhear sessions if you are not in a private place during the session. We will take reasonable steps to ensure your privacy. It is important for you to make sure you find a private place for our session where you will not be interrupted. It is also important for you to protect the privacy of our session on your cell phone or other device. You should participate in therapy only while in a room or area where other people are not present and cannot overhear the conversation.

- Issues related to technology. There are many ways that technology issues might impact Telehealth. For example, technology may stop working during a session, other people might be able to get access to our private conversation, or stored data could be accessed by unauthorized people or companies.

- Crisis management and intervention. Before engaging in Telehealth, we will develop an emergency response plan to address potential crisis situations that may arise during the course of our Telehealth work.

- Efficacy. Most research shows that Telehealth is about as effective as in-person psychotherapy. However, some therapists believe that something is lost by not being in the same room. For example, there is debate about a therapist's ability to fully understand non-verbal information when working remotely.

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**Electronic Communications**
Kerzner Associates uses a platform called doxy.me. It is HIPAA compliant. At our scheduled time, I will send an email invitation to you, and after you click the link provided, you will be directed to enable your phone or computer's camera and speaker. If there is a technological failure and we are unable to resume the connection, you will only be charged the prorated amount of actual session time.

**Fees**
The same fee rates will apply for Telehealth as apply for in-person psychotherapy. However, insurance or other managed care providers may not cover sessions that are conducted via telecommunication. If your insurance, HMO, third-party payor, or other managed care provider does not cover electronic psychotherapy sessions, you will be solely responsible for the entire fee of the session. Please contact your insurance company prior to our engaging in Telehealth sessions in order to determine whether these sessions will be covered.

**Records**
The Telehealth sessions shall not be recorded in any way. Records of the Telehealth session are maintained in the same way that records of in-person sessions, in accordance with our policies.

**Informed Consent**
This agreement is a supplement to the general informed consent that you agreed upon at the outset of your clinical work at Kerzner Associates and does not amend any of the terms of that agreement.

Your signature below indicates agreement with its terms and conditions.

_____
Patient's Name (print name)

_____
Responsible Party (print name)

_____ _____
Patient/Responsible Party Signature Date