New England Wellness Collaborative
1 Richmond Squ Ste 103K
Providence RI 02906-5156
508-812-0613

1. Insurance Disclaimer*

Client Full Name:

Client Address:

Client Mobile Phone Number:

Social Security Number:

Client Date Of Birth:

Client Email:

Parent/ Guardian Name:

Policyholder's Name:

Primary Insurance

Primary Insurance:

Policy Number:

Relationship to patient:

Policyholder's date of birth:

Employer:

Copayment/Deductible Amount $:

Policy Holder Name:

Secondary Insurance

Secondary Insurance:

Policy Number:

Relationship to patient (Self, Spouse, Parent, Step parent, ect.):

Policyholder's date of birth:

Employer:

Other:

Insurance Claim Processing Disclaimer

- [ ] Your signature below indicates that you authorize the release of medical or other information necessary to process insurance claims. Such information is to be released only for the purpose of filing health insurance claims with insurance companies and related agencies. I authorize payment of medical benefits directly to New England Wellness Collaborative for any services rendered.

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2. Standard Intake Questionnaire*

Reason for Therapy

What is your reason for seeking therapy?:

How long have you had these thoughts or experienced this?:

What are some of your triggers?:

What are some things that help this?:

Have you ever seen a therapist before now? If yes, describe the treatment and reason for termination.:

Current Symptoms

(check all that apply)

- [ ] Anxiety
- [ ] Appetite Issues
- [ ] Avoidance
- [ ] Crying Spells
- [ ] Depression
- [ ] Excessive Energy
- [ ] Fatigue
- [ ] Guilt
- [ ] Hallucinations
- [ ] Impulsivity
- [ ] Irritability
- [ ] Libido Changes

- [ ] Loss of Interest
- [ ] Panic Attacks
- [ ] Racing Thoughts
- [ ] Risky Activity
- [ ] Sleep Changes
- [ ] Suspiciousness

Medical History

Please write N/A for those that do not apply

Allergies/Medications you are currently using?:

Previous Diagnoses/Mental Health Treatment:

Current Conditions

Please either write Yes, No, or Unknown

Co-occurring Mental Health & Substance use issues:

Developmental Disability:

Pregnant:

Hypertension:

Hepatitis:

Life Threatening Viral Illness (HIV/AIDS):

Hypercholesterolemia:

Obesity:

Diabetes:

Asthma:

Chronic Obstructive Pulmonary Disease:

Family History

Please write N/A for those that do not apply

How Many People Live in Your Household?:

Present Situation

Work:

Employment Type:

School:

Veteran Status:

Marital Status:

What is your sexual orientation?:

What is Your Current Gender Identity?:

What Sex Where You Assigned At Birth?:

What Pronouns Do You Prefer That We Use When Talking About You?:

Please Describe Your Sexual Activity During The Last Year (Check All That Apply)

- [ ] I was in a monogamous relationship with a man (I had sex with one man only)
- [ ] I was in a monogamous relationship with a woman (I had sex with one woman only)
- [ ] I had multiple female partners
- [ ] I had multiple male partners
- [ ] I had both male and female partners
- [ ] I did not have any sexual partners
- [ ] Not applicable

Do you have child(ren)?:

Have you ever been arrested? If yes, when and why?:

In the past 30 days, have you attended any voluntary self-help groups for recovery that were not affiliated with a religious or faith-based organization. In other words, did you participate in a non-professional, peer-operated organization that is devoted to helping individuals who have addiction related problems such as Alcoholics Anonymous, Narcotics Anonymous, Oxford House, Secular Organization for Sobriety, or Women for Sobriety, etc.:

Average monthly income:

Have you ever tried the following?

(check all that apply)

- [ ] Alcohol
- [ ] Barbitur
- [ ] Bath salts
- [ ] Benzodiaz
- [ ] Cocaine
- [ ] Ecstasy
- [ ] Fentanyl
- [ ] Gamma-hydroxybutyrate
- [ ] Heroin
- [ ] Inhalant
- [ ] Marijuana
- [ ] Methadone
- [ ] Methamphetamine

Other (please list below):

- [ ] Over the counter
- [ ] Steroids
- [ ] Oxycontin/Oxycodone
- [ ] Sythetic Marijuana

If yes, the route of adminatration:

Frequency:

Have you ever been treated for drug/alcohol abuse? If yes, when?:

Age of first use (newborn with substance dependacy, N/A, Unknown, or age of first use):

Do you smoke cigarettes? If yes, how many per day?:

Do you drink caffeinated beverages? If yes, how many per day?:

Have you ever abused prescription drugs? If yes, which ones?:

Additional

Anything else you want the therapist to know?:

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3. Statement for Clients Rights*

Statement for Client Rights

Your exercise of these rights may be subject to reasonable limitations if permitted or required by law, but only with notice to you of the reasons for the limitation and in accordance with your treatment or individual service plan. If you are a minor or you have a court-appointed legal guardian, your rights may be exercised by your parent or guardian on your behalf, again subject to any limitations permitted or required by law. Your psychotherapist can help you understand and exercise these rights, so please take time to read this statement and ask any questions you may have.

1) You have the right to be treated with dignity and respect.

2) You have the right to receive services without discrimination on the basis of race, religion, national origin, gender, sexual orientation, ethnicity, age, disability, political affiliation or marital status.

3) You have the right to be informed of what to expect during the treatment process and/or individual service plan.

4) You have the right to be informed of the cost of services, as soon as that information is available.

5) You have the right to participate in the development of your treatment plan, aftercare planning, service plan, case management, and/or referral for other services.

6) You have the right to be referred to an alternate treatment setting if your psychotherapist is unable to provide appropriate treatment.

7) You have the right to confidentiality regarding your identity, diagnosis, and treatment. With your written consent your psychotherapist will release information to a third party, in accordance with Rhode Island law, federal law, and organizational policy. You also have the right to know that staff members may discuss your case for the purpose of diagnosis, referral, and treatment, and when mandated or allowed by federal and state law. With the following exceptions, information will not be released without your written consent or that of your parent or legal guardian (if you are under 18).

EXCEPTION A: Your psychotherapist has a responsibility to comply with court orders and subpoenas.

EXCEPTION B: In emergency and/or mandated situations, your psychotherapist can act to preserve the safety of the client.

8) You have the right to expect confidentiality from the entire staff with respect to your identity and all aspects of your care.

9) You have the right to be informed of Your psychotherapist's use and disclosure of your personal health information, to authorize certain uses and disclosures of this information, to have an opportunity to agree or object to certain uses and disclosures, to request an amendment to this information and to request an accounting of Your psychotherapist's uses and disclosures of your information. Additional information on these rights is contained in your psychotherapist's Notice of Privacy Practices.

10) You are protected by 42 C.F.R. Part 2. The part regulations "impose restrictions upon the disclosure and use of alcohol and drug patient records which are maintained in connection with the performance of any federally assisted alcohol and drug abuse program." (42 CFS § 2.3(a)) The restrictions on disclosure apply to any information disclosed by a Part 2 program that "would identify a patient as an alcohol or drug abuser..." (42 CFR §2.12(a) (1)) Under 42 CFR § 2.11
a. "Patient" means "any individual who has applied for or been given diagnosis or treatment for alcohol or drug abuse at a federally assisted program."
b. "Records" mean "any information, whether recorded or not, relating to a patient received or acquired by a federally assisted alcohol or drug program." 3

11) You have the right to request to be reassigned to another staff member for treatment purposes.

12) You have the right to terminate services at any time. If you wish to be referred to another agency or practitioner, every effort will be made to refer you to the most appropriate resource.

13) You have the right to file a complaint. If you are unable to resolve your problems with any staff member, you can file a complaint with your psychotherapist's Human Rights Officer, at (508) 812-0613.

14) You have the right to review your record where appropriate, with a clinician, upon written request. We retain the right to withhold services if appropriate services cannot be provided by your psychotherapist.

15) You have the right not to be photographed, observed, videotaped, or audiotaped without your full knowledge and consent.

I understand that my records are protected under RI General Laws 5-37.3 and 40.1-5, Federal Privacy Regulations 45 CFR 160-164 and cannot be disclosed without my consent except as otherwise specifically provided by law. I also understand that if my records involve alcohol/drug abuse or HIV (AIDS) testing they are further processed under Federal Regulation 42 CFR Part 2, Confidentiality of Alcohol and Drug Abuse, and RI Public Law Chapter 88-405, Section 23.

I have been informed of my rights as a client. In addition, the nature and purpose of my treatment, risks, benefits, and alternatives have been explained to me. I have received a copy of these rights. I hereby give permission to my psychotherapist and New England Wellness Collaborative to retain records related to me where appropriate.

I understand, in case of an emergency, my therapist can contact the identified emergency contact.

Therapist Name:

Emergency Contact Information

Relationship:

Name:

Phone:

- [ ] Your signature below indicates that you have been informed of my rights as a client. In addition, the nature and purpose of my treatment, risks, benefits and alternatives have been explained to me. I have received a copy of these rights. I hereby give permission to my psychotherapist and New England Wellness Collaborative to retain records related to me where appropriate.

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4. Notice of Privacy Practice*

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. New England Wellness Collaborative (NEWC) is committed to ensuring the privacy of your protected health information (PHI). PHI is individually identifiable information about your past, present or future health or condition, the delivery of your health care, or payment for your health care. This notice explains how we keep your personal information private and when we may disclose your PHI.

I. How NEWC may use or disclose your PHI without your authorization.
-For Treatment: NEWC may use your PHI for the purposes of medical treatment, medical information or medical services. For example, information obtained by a health care provider may be recorded that is related to your treatment. This information is necessary for the health plan to provide case management and determine appropriate treatment and alternatives.
-For Payment: NEWC may use and share your PHI with others for purposes of making payment for treatment and services that you have received. For example, a claim form that is sent to your insurance company by a treatment provider (e.g. clinician, hospital) that contains information that identifies you, your diagnosis and the treatment plan will be used to determine the payment owed to that provider.
-To Comply with State Licensure: NEWC may use and share your PHI to comply with audit requests from the RI Department of Behavioral Health Care, Developmental Disabilities & Hospitals to check the quality of NEWC client's clinical records.
-For Healthcare Operations: NEWC may use and share your PHI for operational purposes. For example, our medical and quality improvement staff may use your PHI to assess the quality of care and outcomes in your case and those that are similar.
-Appointment: NEWC may use your PHI to provide appointment reminders, information about treatment alternatives and other health-related benefits.
-Health and Safety: Your PHI may be disclosed to avert a serious threat to the health or safety of you or any other person in keeping with the applicable law.
-Persons Involved in Your Care: NEWC may disclose your PHI to persons involved in your care, such as a family member, friend or personal representative (someone with legal authority to act on your behalf), in an emergency, when you are incapacitated or when permitted by law.
-Public Health: NEWC may use and share your PHI with public health authorities to prevent or control disease, injury or disability or for other health oversight activities.
-Required by Law: NEWC may use and share your PHI as required by law. For example, NEWC may disclose information for the following purposes:
o For judicial and administrative proceedings pursuant to legal authority;
o To report information related to victims of abuse, neglect or domestic violence;
o To assist law enforcement officials in their law enforcement duties; and
o To the US Department of Health and Human Services for the purposes of determining whether Psychotherapist is in compliance with federal privacy laws.
-Workers Compensation: Your PHI may be used or disclosed in order to comply with laws and regulations related to

Workers Compensation.
If use or disclosures described above are prohibited or materially limited by other laws, disclosure must reflect the more stringent law.

II. Uses and disclosures requiring your authorization.
Generally, all uses and disclosures other than those listed above will be made only with your written authorization. You may revoke your authorization by submitting a written notice to your Privacy Officer at the address listed below. Your revocation will be effective as of the date of receipt of our written notice.

III. How Your psychotherapist protects your PHI.
We only allow access to information to those people who need to see it to do their work for us. We require that anyone who needs to see personal information sign a confidentiality agreement. We have physical, electronic and procedural security systems in place to keep your personal information safe.

IV. Your health information rights.
You have the right to:
-Request a restriction of certain uses and disclosures of your information. Please specify the restriction requested and to whom you want the restriction to apply. NEWC and Krystal Vasconcelos, LICSW are not required to agree to the requested restriction.
-Obtain a paper copy of this Notice of Privacy Practices upon request;
-Inspect and obtain a copy of your health record as long as we maintain it;
-Amend your health record, depending upon the circumstances;
-Request communications of your PHI by alternative means or at alternative locations;
-Revoke your authorization to use or disclose PHI except to the extent that action has already been taken;
-Receive an accounting of disclosures made of your PHI not related to payment, treatment or operations.

V. Obligations of Your psychotherapist:
-Maintain the privacy of your PHI;
-Provide you with this notice and its legal duties and privacy practices with respect to your PHI;
-Abide by the terms of this notice;
-Notify you if we are unable to agree to a requested restriction on how your information is used or disclosed;
-Accommodate reasonable requests to communicate PHI by alternative means or to alternative locations;
-Obtain your written authorization to use or disclose your PHI for reasons other than those listed above and permitted under law.
NEWC and Krystal Vasconcelos, LICSW reserves the right to change its information practices and to make the new provisions effective for all protected PHI it maintains. Revised notices will be made available to individuals covered by New England Wellness Collaborative and/ or treating psychotherapist within 60 days of a material revision.

VI. Complaints or Questions.
If you believe your privacy rights have been violated, you also have the right to contact the Secretary of the United States Department of Health and Human Services with your complaint.

ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY POLICY & PRACTICES
I have received a copy of the Notice of Privacy Practices.

Notice of Privacy Practice

Acknowledgement of Receipt of Notice of Privacy Policy & Practices

☐ Your signature below indicates that you have received a copy of the Notice of Privacy Practices

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5. Psychotherapy Service Agreement*

This document contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. Although these documents are long and sometimes complex, it is very important that you understand them. When you sign this document, it will also represent an agreement between you and your psychotherapist. We can discuss any questions you have when you sign them or at any time in the future.

PSYCHOLOGICAL SERVICES
Therapy is a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. As a client in psychotherapy, you have certain rights and responsibilities that are important for you to understand. There are also legal limitations to those rights that you should be aware of. I, as your intake counselor, have corresponding responsibilities to you. These rights and responsibilities are described in the following sections.

Psychotherapy has both benefits and risks. Risks may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness, because the process of psychotherapy often requires discussing the unpleasant aspects of your life. However, psychotherapy has been shown to have benefits for individuals who undertake it. Therapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems. But, there are no guarantees about what will happen. Psychotherapy requires a very active effort on your part. In order to be most successful, you will have to work on things we discuss outside of sessions.

Our meeting today involves a brief description of what brings you to treatment; your symptoms, family structure, and past traumas. The first 2-3 sessions with your assigned therapist will involve a comprehensive evaluation of your needs. By the end of the evaluation, he or she will be able to offer you some initial impressions of what your work might include. At that point, they will discuss your treatment goals and create an initial treatment plan. You should evaluate this information and make your own assessment about whether you feel comfortable working with your therapist. If you have questions about their procedures, you should discuss them whenever they arise. If your doubts persist, your therapist will be happy to help you set up a meeting with another mental health professional for a second opinion.

APPOINTMENTS
Appointments will ordinarily be 40-45 minutes in duration, once per week at a time agreed upon, although some sessions may be more or less frequent as needed. The time scheduled for your appointment is assigned to you and you alone. If you need to cancel or reschedule a session, your psychotherapist’s policy is that you provide 24 hours notice. If you miss a session without canceling, or cancel with less than 24 hour notice, our policy is to collect the cost of a session, as that slot can no longer be filled. Refer to the No show / Late Cancellation policy.

INSURANCE

In order to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. With your permission, our billing service will assist you in filing claims and ascertaining information about your coverage, but you are responsible for knowing your coverage and for letting our receptionist know if/when your coverage changes.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. Managed Health Care plans such as HMOs and PPOs often require advance authorization, without which they may refuse to provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While a lot can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end. Some managed-care plans will not allow your psychotherapist to provide services to you once your benefits end. If this is the case, your psychotherapist will find another provider who will help you continue your psychotherapy.

You should also be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. (Diagnoses are technical terms that describe the nature of your problems and whether they are short-term or long-term problems. All diagnoses come from a book entitled the DSM-V. Your therapist will review your diagnosis with you following your assessment period (the first 2-3 sessions with your therapist). Your insurance company may also request additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files and will probably be stored in a computer.

In addition, if you plan to use your insurance, authorization from the insurance company may be required before they will cover therapy fees. Many policies leave a percentage of the fee (which is called co-insurance) or a flat dollar amount (referred to as a co-payment) to be covered by the patient. Either amount is to be paid at the time of the visit by check or cash. In addition, some insurance companies also have a deductible, which is an out-of-pocket amount; that must be paid by the patient before the insurance companies are willing to begin paying any amount for services. This will typically mean that you will be responsible to pay for initial sessions until your deductible has been met; the deductible amount may also need to be met at the start of each calendar year. Once we have all of the information about your insurance coverage, we will discuss what we can reasonably expect to accomplish with the benefits that are available and what will happen if coverage ends before you feel ready to end your sessions. It is important to remember that you always have the right to pay for services yourself to avoid the problems described above.

COURT

I understand that New England Wellness Collaborative or my treating psychotherapist, will not administer evaluative or diagnostic services or engage in any type of treatment for issues that may involve disputes regarding legal or physical custody of a minor child, divorce proceedings, forensic evaluations, or any litigation in any form, whether civil, criminal, or family court proceedings. In the event of a mandatory court appearance, I agree to pay New England Wellness Collaborative or my treating psychotherapist the fee of $125/hour.

PROFESSIONAL RECORDS

Your psychotherapist is required to keep appropriate records of the psychological services provided. Your records are maintained in a secure location in the office. Your treating therapist keeps brief records noting that you were here, your reasons for seeking therapy, the goals and progress we set for treatment, your diagnosis, topics discussed, your medical, social, and treatment history, records received from other providers, copies of records sent to others, and your billing records. Except in unusual circumstances that involve danger to yourself, you have

the right to a copy of your file. Because these are professional records, they may be misinterpreted and / or upsetting to untrained readers. For this reason, it is recommend that you initially review them with your treating provider, or have them forwarded to another mental health professional to discuss the contents. You also have the right to request that a copy of your file be made available to any other health care provider at your written request.

CONFIDENTIALITY
Your psychotherapist's policies about confidentiality, as well as other information about your privacy rights, are fully described in a separate document entitled Notice of Privacy Practices. You have been provided with a copy of that document. Please remember that you may reopen the conversation at any time during your work here.

CONSENT TO PSYCHOTHERAPY
Your signature below indicates that you have read this Agreement and the Notice of Privacy Practices and agree to their terms.

Psychotherapy Services Agreement

Consent to Psychotherapy

- [ ] Your signature below indicates that you have read this Agreement and the Notice of Privacy Practices and agree to their terms.

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6. No Show/Late Cancel Appointment Policy*

No Show/Late Cancel Appointment Policy

NEWC is committed to providing the best treatment. In order to do this, consistency with care and regularly scheduled appointments are necessary. The following applies:

1. Any appointment NOT canceled within 24 hours will be considered a late cancellation.
2. Any appointment late-canceled or any no-show appointments will be assessed a missed fee of $75.00
3. Extenuating circumstances may reduce or eliminate the fee and will be put into consideration on a case-to-case basis
4. Payment plans can be made for the fee. If you miss a payment, you will not be able to schedule your next appointment until arrangements are made
5. 3 late-canceled or no-show appointments in a six-month period are grounds for termination from treatment
6. 3 canceled appointments in a 3 month period are grounds for termination from treatment
7. Missing the initial and/or a rescheduled appointment is grounds for termination from treatment

Thank you for your commitment to your treatment and for valuing your psychotherapist’s time.

☐ Your signature below indicates that you have read and understood the no show/late cancel appointment policy

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7. NEWC Credit / Debit Card Payment Consent*

Client name:

(Card holder) Name on card if different than client:

Card Type:

Last 4 digits of card number:

Expiration Date:

I authorize New England Wellness Collaborative to charge my credit/debit/health account card for professional services every Friday following my scheduled session. I understand that if I do not cancel my session with 24 hour notice I may be subject to a cancelation fee as described in the attendance agreement form.

I verify that my credit card information, provided above, is accurate to the best of my knowledge. If this information is incorrect or fraudulent or if my payment is declined, I understand that I am responsible for the entire amount owed and any interest or additional costs incurred if denied. I also understand by signing and initialing this form that if no payment has been made by me, my balance will go to collections if another alternative payment is not made within thirty days.

Client Initials:

Card holder Initials (If different than client):

- [ ] Your signature below indicates that you authorize New England Wellness Collaborative to charge my credit/debit/health account card for professional services every Friday following my scheduled session. I understand that if I do not cancel my session with 24 hour notice I may be subject to a cancelation fee as described in the attendance agreement form.
- [ ] Your signature below indicates that you verify that my credit card information, provided above, is accurate to the best of my knowledge. If this information is incorrect or fraudulent or if my payment is declined, I understand that I am responsible for the entire amount owed and any interest or additional costs incurred if denied. I also understand by signing and initialing this form that if no payment has been made by me, my balance will go to collections if another alternative payment is not made within thirty days.

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8. Social Media Policy*

Social Media Policy

This document outlines my office policies related to use of Social Media. Please read it to understand how I conduct myself on the Internet as a mental health professional and how you can expect me to respond to various interactions that may occur between us on the Internet. If you have any questions about anything within this document, I encourage you to bring them up when we meet. As new technology develops and the Internet changes, there may be times when I need to update this policy. If I do so, I will notify you in writing of any policy changes and make sure you have a copy of the updated policy.

E-MAILS, CELL PHONES, COMPUTERS AND FAXES ARE NOT PRIVATE:
No form of client communication is 100 percent guaranteed to be private. When email, Facebook and other social media communication sources are utilized there are ethical pitfalls to be aware of as a user.

The privacy and confidentiality of e-mail and cell phone communication can be compromised by unauthorized people gaining access. E-mails, in particular are vulnerable to such unauthorized access due to the fact that servers have unlimited and direct access to all emails that go through them. Although I am exploring various encryption software programs to protect your privacy, my emails and data on my computers may not be encrypted, it is always a possibility that faxes can be sent to the wrong address, and computers, including laptops, may be stolen. My computers are equipped with a firewall, virus protection and passwords, and I also password-protect and back up all confidential information from my computers (stored off-site) on a regular basis.

If you need to cancel or change an appointment time; call or text (SMS) will get the message to me in a timely manner. Please notify me if you decide to avoid or limit, in any way, the use of e-mails, cell phones text messages, faxes, or storage of confidential information on computers. If you communicate confidential or private information via text or e-mail, I assume that you have made an informed decision, will view it as your agreement to take the risk that such communication may be intercepted, and I will honor your decision to communicate on such matters via e-mail. Please do not use e-mail or faxes for emergencies. Due to computer or network problems, e-mails may not be deliverable, and I may not check my e-mails or faxes daily.

I prefer to use e-mail to arrange or modify appointments only. If you e-mail me content related to your therapy sessions, please note that e-mail is not completely secure or confidential. If e-mail communication outside of therapy requires more than 5 minutes to read and respond to, I may charge for my services rendered in 15 minutes increments. Please indicate if you intend to pay these charges, or I will save the e-mail for review during your session time.

Be aware that all e-mails are retained in the logs of your and my internet service providers, while it is unlikely that someone will be looking at these logs, they are, in theory, available to be read by the system administrator(s) of the internet service provider. E-mails that I receive from you and any responses that I send to you become part of your legal record and may be revealed in cases where your records are summoned by a legal entity.

FRIENDING: I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc.). I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet and we can talk more about it.

FOLLOWING: I have no expectation that you as a client will want to follow my blog, snapchat, Facebook or Twitter stream. However, if you use an easily recognizable name on snapchat or Twitter and I happen to notice that you've followed me there, we may briefly discuss it and its potential impact on our working relationship. My primary concern is your privacy. Note that I will not follow you back. I only follow personal friends and colleagues on snapchat and Twitter and I do not follow current or former clients on blogs or social media. My reasoning is that I believe 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 my personal curiosity. In addition, viewing your online activities without your consent and without our explicit agreement towards a specific purpose could potentially have a negative influence on our working relationship. If there are things from your online life that you wish to share with me, please bring them into our sessions where we can view and explore them together.

INTERACTING: Please do not use messaging on Social Networking sites such as Twitter, Facebook, or LinkedIn to contact me. These sites are not secure and I may not read these messages in a timely fashion. Do not use Wall postings, @replies, or other means of engaging with me in public online if we have an already established client/therapist relationship. Engaging with me 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.

If you need to contact your therapist between sessions, the best way to do so is to utilize the direct email that was provided in your initial confirmation email for any quick administrative email such as changing appointment times. Please ask your therapist for the direct business line. See the email section in the informed consent document for more information regarding email interactions.

USE OF SEARCH ENGINES: It is NOT a regular part of my practice to search for clients on Google or Facebook or other search engines. Extremely rare exceptions may be made during times of crisis. If I have a reason to suspect that you are in danger and you have not been in touch with me via our 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 I ever resort to such means, I will fully document it and discuss it with you when we next meet.

BUSINESS REVIEW SITES: You may find NEWC on sites such as Yelp, Healthgrades, Yahoo Local, Google, our Facebook page or other places which list businesses. Some of these sites include forums in which users rate their providers and add reviews. Many sites search for business listings and add the business to these sites automatically.
Please know that if you see NEWC or your therapist on one of these sites it is NOT a request for a testimonial, rating or endorsement from you as the client. You have the right to review on any of these sites whether it is positive or negative. However, due to confidentiality, I cannot respond to any review on any of these sites. Also, be aware that if you are using these sites to communicate indirectly with me about your feelings about our work, there is a good chance that I may never see it. Please bring your feelings and reactions to our work directly into the therapy sessions. This can be an important part of therapy, even if you decide we are not a good fit. None of this is meant to keep you from sharing that you are in therapy with me with whomever you like. Confidentiality means that I cannot tell people that you are my client and my code of ethics prohibits me from requesting testimonials. You are more than welcome to tell anyone you wish that I'm your therapist or how you feel about the treatment I provide to you, in any forum of your choosing.

If you choose to write something on a business review site or our Facebook page, please keep in mind that you will be sharing personally revealing information in a public forum. I urge you to create a pseudonym that is not linked to your regular e-mail address or friend networks for your own privacy and protection.

If you feel I have done something harmful or unethical and you do not feel comfortable discussing it with me, you can contact the State of Rhode Island Department of Health, which oversees licensing, and they will review the services I have provided.

CONCLUSION: If you have any questions or concerns about any of these policies and procedures or regarding our potential interactions on the internet, please bring them to my attention today or during any of our future sessions so we can discuss them.

Acknowledgement of Review of Social Media Policy: I release the treating psychotherapist and New England Wellness Collaborative from any liability arising from any disclosing of personal information by myself through e-mail or social media, provided that said disclosure of information is done substantially in accordance with applicable law and this social media policy. Signature below also implies that we reviewed the social media policy and the date that we reviewed it.

- [ ] Your signature below indicates that you release the treating psychotherapist and New England Wellness Collaborative from any liability arising from any disclosing of personal information by myself through e-mail or social media, provided that said disclosure of information is done substantially in accordance with applicable law and this social media policy. Signature below also implies that we reviewed the social media policy and the date that we reviewed it.

New England Wellness Collaborative

1 Richmond Squ Ste 103K
Providence RI 02906-5156
508-812-0613

9. Authorization to Release*

Client Full Name:

Client Date Of Birth:

Therapist Name:

Authorization for Behavioral Health and Primary Care Physicians to Share Confidential Information
Please only select ONE of the two options below:

- [ ] I give permission to my therapist and/or New England Wellness Collaborative and my Primary Care Physician or Behavioral Health Physician to share information about my diagnosis and/or treatment related to substance abuse, mental health, or medical history, NOT including the results of a blood test for antibodies to the human immunodeficiency virus (HIV). I understand the purpose of sharing information is to help me receive better care. This consent form expires 90 days from the date of signing and I can choose to cancel it at any time.

- [ ] I DO NOT give permission to my therapist and/or New England Wellness Collaborative and my Primary Care Physician or Behavioral Health Physician to share information about my diagnosis and/or treatment related to substance abuse, mental health, or medical history, NOT including the results of a blood test for antibodies to the human immunodeficiency virus (HIV). I understand the purpose of sharing information is to help me receive better care. I also understand that my refusal to share information does not affect my insurance coverage. This consent form expires 90 days from the date of signing and I can choose to cancel it at any time.

Authorizes New England Wellness Collaborative and my psychotherapist to:

OBTAIN from: (Please list the name and address of your Primary Care Physician or Behavioral Health Physician):

RELEASE from: (Please list the name and address of your Primary Care Physician or Behavioral Health Physician):

The information to be released pertaining to my identity prognosis diagnosis or treatment shall include written or verbal information related to:

- [ ] Discharge Summary
- [ ] Progress Notes
- [ ] Psychosocial History
- [ ] Treatment Summary
- [ ] Psychiatric Evaluation
- [ ] Psychological Testing/Report

Other: (be specific):

This information is needed for the following purpose(s):

- [ ] Evaluation and Treatment

Other: (be specific):

Permission for the exchange of information will continue for the duration of the client's treatment. Permission may be withdrawn at any time through a signed written statement.

I understand that records with my psychotherapist and New England Wellness Collaborative are protected under RI General Laws and cannot be disclosed without my written consent except as otherwise specifically provided by law. If my records involve alcohol or drug abuse treatment they also be protected under the Federal Regulation 42 CFR, Confidentiality of Alcohol and Drug Abuse.

I release my psychotherapist and New England Wellness Collaborative and the fee for service clinicians from any liability arising frim the release of this information to such persons/agencies, provided that said release of information is done substantially in accordance with applicable law.

- [ ] By checking the box, I agree that I have read and understand the above statements and do herein voluntarily consent to disclosure of the above information to those person/agencies named above.

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10. Consent for Supervised Clinical Treatment*

Client Full Name:

Therapist Name:

Supervising Clinicians, Krystal Vasconcelos, LICSW and Kristeen Rocha, LICSW

The clinician who is providing your treatment is not part of your insurance plan network. The supervisor of your treating clinician is a part of your insurance network. The clinician and the supervisor are following the SUPERVISORY PROTOCOL:

I. Your insurance plan will authorize services and payment for services to the Supervisor based on medical necessity criteria. The Supervisor may refer the Member to a supervisee for the provision of these services.

II. Supervision and treatment will be provided within the preferred practice guidelines of your insurance plan and according to medical necessity criteria. At all times, Supervisors shall require Supervisees to comply with the protocols and requirements of your insurance company payor and the requirements of all applicable regulatory authorities. Such requirements include, but are not limited to, not billing Members for any amounts except Member Expenses and charges for services not covered under the Member's Benefit Contract.

III. Provider will conduct primary source verification of the Supervisee's training and education: A. Professional License
B. Graduate School and/or Residency
C. Medicare/Medicaid sanctions
D. National Practitioner Data Base
E. License is without sanction, restriction, or limitation by appropriate state agency, State Board of Medical Examiners, or the Federation or State Medical Boards
F. Work history – any gaps six months or longer are accounted for specialized Training, where applicable

III. Members must be informed that they are being treated by a Supervisee and must sign a written consent to this effect.

IV. Supervisees will practice within the scope of their training and abide by the ethical principles of their discipline's licensing Board, that of their Supervisor and of the American Psychiatric Association.

VI. Supervision will follow these guidelines:
A. Supervisors, who are credentialed by your insurance company and in good standing with the network, will provide supervision.
B. The Supervisor must have regular one-on-one supervision with the Supervisee to review treatment provided to Members at a minimum of once weekly. Supervision must be documented in the Member's chart and kept on file.

VII. Prior authorization (when required) and billing for services must be submitted under the Supervisor’s name, using the authorization number given by your insurance plan at the time of admission/pre-certification if prior authorization is required.

Your insurance plan may periodically conduct chart audits to ensure compliance with their policies and procedures.

Please sign below to consent to this agreement.

Thank you for your commitment to your treatment.

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11. Telehealth Treatment Consent*

Information and Informed Consent for Telemental Health Treatment

Telemental health is live two - way audio and video electronic communications that allows therapists and clients to meet outside of a physical office setting.

Client Understanding

I understand that telemental health services are completely voluntary and that I can withdraw this consent at any time.

I understand that none of the telemental health sessions will be recorded or photographed.

I agree not to make or allow audio or video recordings of any portion of the sessions.

I understand that the laws that protect privacy and the confidentiality of client information also apply to telemental health, and that no information obtained in the use of telemental health that identifies me will be disclosed to other entities without my consent.

I understand that telemental health is performed over a secure communication system that is almost impossible for anyone else to access. I understand that any internet based communication is not 100 % guaranteed to be secure.

I agree that the therapist and practice will not be held responsible if any outside party gains access to my personal information by bypassing the security measures of the communication system.

I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties.

I understand that I or my therapist may discontinue the telemental sessions at any time if it is felt that the video technology is not adequate for the situation.

I understand that if there is an emergency during a telemental health session, then my therapist may call emergency services and/ or my emergency contact.

I understand that this form is signed in addition to the Notice of Privacy Practices and Consent to Treatment and that all office policies and procedures apply to telemental health services.

I understand that if the video conferencing connection drops while I am in a session, I will have an additional phone line available to contact my therapist, or I will make additional plans with my therapist ahead of time for re - contact.

I understand a “no show” or late fee will be charged if I miss an appointment or do not cancel within 24 hours of scheduled appointment. I understand credit card or other form of payment will be established before the first session.

I understand my therapist will advise me about what telemental health platform to use and she will establish a video conference session.

☐ I hereby give my informed consent for the use of telemental health in my care.

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12. Grievance Policy*

NEWC promotes open communication with families. Prior to using grievance procedures, families are encourages to speak with the therapist to resolve any issues and concerns. A grievance may be initiated by the person supported or a family member. When relevant, the the clinical supervisor may arrange a mediation session between the family and staff member involved in the particular issue.

Process of filing a grievance:
1) Inform your therapist and Clinical Director of the situation immediately. Therapist will document the process in the case record, including any letters and communication from family or person supported.
2) Person supported or family member initiating the grievance is given a new copy of the policy for referral.
3) Person supported or family member is given a written copy of the final resolution of the grievance and a copy is filed in the clinical record.
4) Person supported or family member is entitled to respond in writing to the Executive Director.
5) Administrative staff will maintain a respectful relationship with the person supported and family during the grievance process.

Administrative Level:
1) The Clinical Director will maintain communication with the Executive Director throughout the process.
2) The Clinical Director will meet with the family and/or staff within 10 business days of receiving the complaint.
3) If a satisfactory resolution is not reached, the person supported can write a letter outlining the concerns to the Executive Director or designee.
4) The Executive Director or designee will arrange a meeting within 10 business days of receiving the letter.
5) The Executive Director will send a letter stating the outcome within 10 business days of the meeting.
a. If it is determined that services should discontinue, appropriate notification to the applicable state agency must be communicated.

NEWC is committed to providing the best possible care for you and your child. In the event that you and your Therapist are unable to resolve a specific issue, problem or concern you will be directed to contact the Clinical Director.

In most cases the issue or concern can be resolved at this level. If you are not satisfied with the result you receive, you may arrange to meet with the Clinical Director of the program. In instances where the concern involves a particular staff member, the Director may arrange a mediation session between you and the staff member.

If you are unsatisfied with the response at this level, you may write a letter outlining your concerns to the Executive Director or his designee within 10 business days. S/He will arrange a meeting within 10 business days of receiving your letter to meet and discuss your concerns. After the meeting, you will receive a letter stating the outcome within 10 business days.

- [ ] By checking the box and the signature below, you agree that you have read and understand the grievance procedure.