Merrimack Valley Counseling Association

Northcrest Executive Office Park •39 Simon Street, Unit #2A •Nashua, NH 03060 •(603)888-4347 • Fax (603)577-9157
20 Merrit Parkway, 2nd Floor, Nashua, NH 03062 • (603)402-9365 • Fax (603)402-9389

Client Information Sheet

For Office Use Only

Account Number: ______________________ **Therapist:** ________________________
Date of First Session: ______________________ **DIAG Code:** ________________________
Testing Given: ______________________

Eval ☐ **Individual** ☐ **Couple** ☐ **Family** ☐ **Group** ☐

Client Information

Name: ____
Last First M.I.

Address: ____
Number Street Name Apt/Unit Number

____
City State Zip Code

D.O.B.: ________/ ________/ ________ Age: __________ Sex: __________
MM DD YY

S.S.#: __ __ __ - __ __ __ - __ __ __ __

Phone Numbers: (_____) ________________ (_____) ________________
Home Number Work/Cell/Alternative Number

Marital Status: Married ☐ Single ☐ Separated ☐ Divorced ☐ Widower/Widow ☐

Employer: ____
Name Address

Occupation: ______________________ ______________________
Title/Position Length of Service/Years at Position

Education: ☐ High School ☐ GED/High School Equivalency
☐ Trade School ☐ College: ________________
Level

Spouse / Significant Other Information

Name: ______________________ ______________________
Last Name First Name Relationship to Client

Address: ____
Number Street Name Apt/Unit Number

____
City State Zip Code

D.O.B. ________/ ________/ ________ Age: __________ Sex: __________
MM DD YY M/F

S.S.# __ __ __ - __ __ - __ __ __ __

Primary Insurance Information

Subscriber Name: ____ S.S.#: ___ ___ ___ - ___ ___ - ___ ___ ___ ___
Last Name First Name

Subscriber DOB: __________/ __________/ __________
MM DD YY

Ins. Company Name: ____ Phone #: ____________________________________
(usually on the back of your insurance card)

Subscriber ID# ____ Group #: ____________________________________

Ins. Rep Name: ____ Date Called: _________________________________

Is the Plan: HMO ☐ PPO ☐ Personal Plan ☐ Effective Date of Coverage: ____________________

Secondary Insurance Information

Subscriber Name: ____ S.S.#: ___ ___ ___ - ___ ___ - ___ ___ ___ ___
Last Name First Name

Subscriber DOB: __________/ __________/ __________
MM DD YY

Ins. Company Name: ____ Phone #: ____________________________________
(usually on the back of your insurance card)

Subscriber ID# ____ Group #: ____________________________________

Ins. Rep Name: ____ Date Called: _________________________________

Is the Plan: HMO ☐ PPO ☐ Personal Plan ☐ Effective Date of Coverage: ____________________

Emergency Information

Emergency Contact: ____ ______________________________
Last Name First Name Relationship to Client

Address: ____
Number Street Name Apt/Unit Number

____
City State Zip Code

Phone Number: (______) ___________________________ (_____) ______________________________
Home Number Work//Alternative Number

Primary Physician: ___________________________ ________________ ___________________________________
Last Name First Name Hospital Affiliation/Practice Name

Address: ____
Number Street Name Suite/Unit Number

____
City State Zip Code

Phone Number: (_____) __________________________ (_____) ____________________________________
Office Number Emergency Page/Emergency Hotline Number

Statement of Confidentiality

Within certain limitations, information concerning you and (if applicable) your child(ren) during the course of treatment will be kept strictly confidential and will not be revealed to any other person and/or agency without your written consent. At your request, any or all parts of your records can be released to any person and/or agency you designate (either verbally or in writing). There are certain situations in which Psychologists, mental health professionals and/or medical professionals are required by law to reveal information without your permission. These include:

1) When information is obtained suggesting clear suspicion that physical abuse, sexual abuse, or physical neglect has occurred to a minor;
2) When grave bodily harm or death is threatened to another person;
3) When serious suicidal intentions are conveyed and a client or their guardian refuses voluntary treatment to ensure the client's safety;
4) When a court of law issues a subpoena for information obtained during treatment in response to the order of a court of law; and
5) Reporting as mandated by HIPAA, The Health Insurance Portability and Accountability Act.

If you have any questions and/or concerns regarding your rights to confidentiality, please discuss them with your psychologist at the time of your appointment.

Confidentiality Agreement with On-Call Providers

If my clinician/physician/ARNP is not available to review my records for a consultation in an emergency situation, I consent to authorize the on-call clinician at Merrimack Valley Counseling Association to review my records.

Session Payment Policy

The term "one therapy hour" is defined by most HMO, PPO and managed care companies as a 45-50 minute session (not a full hour or 60 minutes). To continue with our standard philosophy and concern for all clients, we will provide additional time for each client above the standard 45-50 minutes should the therapist's schedule allow this flexibility.
A 45-50 minute session is charged at our standard rate from $150. 00 to $250.00 based on the level of expertise of the provider (examples: Master's Doctorate, ARNP, or MD). A 25 minute session (i.e. a half-hour appointment) is charged at a rate of $75.00, etc. Fees are collected prior to the beginning of each session. For your convenience, we accept cash, check, Visa, Mastercard, or American Express.
We are currently mental health providers for several insurance carriers. Please ensure that you have your insurance card with you when you arrive for your session so that we may make a copy of it for your file. Please notify us immediately of any changes in your insurance coverage.

Cancellation Policy / Fee and Billing Policy

Should you need to cancel or change future appointments, 24 hour notice is requested. Because appointments with psychologists are in great demand, and because your appointment time is reserved only for you and cannot be filled without sufficient notice, missed appointments or those canceled less than 24 hours in advance will be billed directly to you for the full session amount. Exceptions are made in cases where only extraordinary circumstances prevent adequate cancellation notification. Insurance will not cover any portion of the fees for a missed or canceled appointment.

Insurance Provider Release of Records Consent

In certain circumstances, we may need to release limited information to your insurance provider in order to obtain payment for your scheduled sessions. In order for us to release the necessary information, we must obtain your signed consent to do so. Please read the statement below and sign on the signature line as indicated.

I authorize Merrimack Valley Counseling Association to release information to my insurance company as is necessary to obtain payment for services provided.

____________________________ _______________ _______________________
Signature Date Witness Signature

Client's/Patient's Rights

I acknowledge that I have received or been offered a copy of the Mental Health Bill of Rights and a copy of the HIPAA privacy laws.

____________________________ _______________
Signature Date

Medical and Payment Authorization/Assignment of Payment / Promise to Pay

I have read the cancellation policy listed above and understand that except in extraordinary circumstances, missed appointments and those canceled without 24 hours notice will be billed directly to me at the full session rate. I also understand that insurance does not cover fees for missed appointments.
I also authorize my mental health provider or the health care vendor providing services or benefits to release any mental health, substance abuse assessments or medical treatment information necessary to effect treatment or claim payments to Merrimack Valley Counseling Association.
I authorize payment of benefits to the Merrimack Valley Counseling Association for services rendered, providing other arrangements have not been previously negotiated. I also understand that I am responsible for any services and/or fees that are not covered by my insurance company.

Note: If client is a minor, parent and/or guardian will sign

___________________________________ __________________ ____________________
Signature Date Witness Signature

Technology

It is the policy of this agency to limit electronic communication with our clients, including texting, e-mails, LinkedIn©, or the use of cell phones. Please sign below if you are agreeable to having us text, send e-mail and/or cell phone messages.

________________ _____________________
Date Signature

Safety Contract

I contract with my therapist, _______________________, not to engage in any self-destructive behaviors that would put me or others in imminent danger. I contract to call my therapist if I feel I'm in danger. If my therapist is not available, I agree to speak to the on-call therapist. If no direct contact is available, I agree to go to the nearest hospital emergency room.

Southern NH Medical Center Tel. (603) 577-2000 or (603) 577-2728 **St. Joseph's Hospital Tel. (603) 882-3000**

This contract shall remain in effect for as long as I am in treatment.

Signature:______________________________________ **Date __________________________**

X My signature on this form attests to the fact that I do not and/or my spouse does not have (if applicable) any other insurance coverage in addition to my primary carrier.

_______________________________________ ______________________
Signature Date