210 Bear Hill Road
Waltham, MA 02451
T: (781) 966.0070
F: (781) 915.0755

Dear Patient:

Welcome to Waltham Behavioral Health. Thank you for choosing our practice for your behavioral health needs. Please visit our website for basic information about our practice and providers. You will find our office telephone numbers and map along with brief bios of all our providers.

Please complete all the forms below. Please bring all forms with you when you come to the office. Consultation appointments last for one hour. If you know you must cancel an appointment, please call a minimum of 24 hours in advance (preferably 48 hours). For your convenience, cancellations may be left on our answering machine 24 hours a day.

Please be sure to bring your insurance card and co-payment each time you come to the office. We also request you bring a list of all your current medications and any over-the-counter medications/supplements you are taking.

If you have any additional questions, please feel free to call the office.

We look forward to seeing you on the day of your appointment.

Sincerely,

The Staff of Waltham Behavioral Health, LLC

Please Note – Appointment reminders will be sent via text message at the telephone number you provided when you made your appointment.

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TREATMENT AGREEMENT

Treatment of Adults: During a medical evaluation or ongoing treatment, your prescriber may recommend psychotherapy as a part of your treatment plan.

Treatment of Minors (under the age of 18): All patients under the age of eighteen (18) must be accompanied by a legal guardian during their first visit. A parent/guardian is required to authorize the treatment of minors. ***Waltham Behavioral Health, LLC (WBH) will not undertake treatment of minors without parental consent.*** A parent, guardian or any other adult accompanying a minor for treatment are responsible for that child and all costs associated with their treatment. In the treatment of minors, parents/guardians have a right to access and authorize the release of medical information. A child has a right to confidentiality with their provider except for information that infers danger to the child or others. When a minor patient turns eighteen their treatment, information and records revert to their control.

Confidentially: Information regarding your care here is entirely confidential. No information will be provided to a third party unless we have your written authorization for its release. In rare cases we are required by law to disclose confidential information including situations of known or suspected child abuse, elder abuse or likelihood of harm to yourself or specifically identified individuals.

Grievance Procedure: As a WHB patient you have the right to register dissatisfaction. The facility is open to recommendations and will respond to complaints. Complaints should be registered with your therapist or provider. However, if this is not possible or acceptable, you may communicate your grievance directly to the WBH Practice Manager. *You will never be penalized for filing a complaint.*

Request for Medical Records: Medical records can be obtained for an administrative fee of $25. This fee covers the full administrative costs incurred for this process. It may take up to seven (7) days from the date of the request to receive your records.

Declaration of Agreement Regarding Payment and Missed/Cancelled Appointments:
By signing below, I understand and agree to the following:

- All co-payments are due at the time of treatment
- **Reminder calls/texts are a courtesy:** I am responsible for knowing the dates/times of my appointments regardless of receipt of a reminder call or text
- If I am unable to keep an appointment I must notify WBH at (781) 966-0070 as soon as possible and **no fewer than 24 hours prior to the scheduled appointment**
- In the event of a missed appointment or failure to cancel with 24 hours' notice, I agree to pay a **$75 late cancellation fee**
- Repeatedly missing or cancelling appointments without adequate notice may result in discharge from the practice
- A fee of $25 will apply to all returned checks

Signature: _____ **Date**:_____

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Patient Information Form

Please complete all applicable entries

PATIENT NAME:(Last, First, Middle):_____

Responsible Party (if patient is a minor):_____

Date of Birth: _____ Age: _____

Gender: _____ SS#: _____

Cell Phone:_____Home/Work Phone: _____

Email: _____

PRIMARY HEALTH INSURANCE: _____

Subscriber ID#: _____ Group#: _____

Policy Holder: _____ DOB: _____

SECONDARY HEALTH INSURANCE: _____

Subscriber ID#: _____ Group#: _____

Policy Holder: _____ DOB: _____

LOCAL PHARMACY:_____Addr:_____City_____

MAIL-AWAY PHARMACY:_____Addr:_____City_____

Phone: _____ Fax:_____

Referral Source: ☐Alt. Provider ☐Insurance ☐Patient ☐PCP

☐School ☐Our Website ☐Other _____

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Financial Policy

We are committed to providing you with the best possible care and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, policies or any costs for which you may be responsible.

- For patients with insurance we are contracted with: **all copays, deductibles and co-insurance are due at the time of service**
- For patients with non-contracted insurance or no insurance**: full, out-of-pocket payment is due at the time of service**
- If your insurance company requires a referral from your primary care physician, the referral must be in place by the date of service: **without this referral in place, your appointment will need to be rescheduled**
- We accept cash, personal checks and all major credit cards

Treatment may be denied for the following reasons:

- A referral is not obtainable when required by the patient's insurance
- A patient has been delinquent of back payments and/or the account has been sent to a collection agency
- A patient has missed more than three previous appointment and has been advised of being denied another appointment
- A minor under eighteen is unaccompanied by an adult

I,_____, have read and understand the conditions for payment to Waltham Behavioral Health, LLC as outlined above.

I hereby authorize WBH to apply for benefits on my behalf for covered services rendered by them, or their order. I request that payment from my insurance company and/or attorney from PIP benefits or settlements proceeds, be made to WBH.

I understand that my insurance carrier may require a referral from my primary care physician as authorization for treatment and, if so, **it is my responsibility to obtain this referral**. If a claim is denied to my insurance carrier for failure to obtain a referral, I will be held responsible for the full balance of the claim.

I permit a copy of this form to be used in the place of the original.

Signature:_____ Date:_____

We accept cash, personal checks, Visa. MasterCard, Discover, and American Express.

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Unpaid Accounts Policy

Our office will make every effort to communicate with you regarding your account and will present reasonable options for payment. In the event a bill goes unpaid and you do not contact our billing department to discuss payment options, or you do not satisfy your account balance for 120 days, the account will be turned over to a collections agency.

Patient Name:_____Date:_____

Signature:_____Parent/Guardian:_____

Prescription Refill Policy

If you have missed/cancelled your last appointment, you may be subject to a $25.00 prescription refill charge if a prescription is needed prior to you next scheduled appointment. This is a processing fee which can occur at the discretion of the provider on call.

Patient Name:_____Date:_____

Signature:_____Parent/Guardian:_____

Medical Records Policy

It is our policy to obtain any past medical/psychiatric records to ensure comprehensive and collaborative care. If a patient does not consent below, he/she will be referred to another facility.

I, _____, consent to WBH requesting past medical/psychiatric records from previous providers.

Signature:_____ Date:_____

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HIPAA Notice of Privacy Practices

We are required by law to maintain the privacy of all individuals in our care and to provide this notice of legal duties and privacy practices with respect to the protection of health information.

Signing below acknowledges that you have received this notice of our Privacy Practices.

Patient Name:_____ Date:_____

Signature:_____

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NOTE: This Information is confidential.

Demographic Information:

Name: Date:

Date of Birth: Relationship Status:

Age: SSN:

Gender: ◯ M ◯ F ◯ Transgender

Home/Mobile Phone: Is it ok to leave a message for you at this number? Y / N

Work Phone: Is it ok to leave a message for you at this number? Y / N

Email: Is it ok to email you? Y /N

Mailing Address:

Emergency Contact Name & Relationship:

Emergency Contact Phone:

How were you referred?

Is this person aware that you are receiving services at WBH? Y / N

Please note that by providing us with this emergency contact's information, you are giving WBH the rights to contact this person at any time if we have determined that the above patient is in an emergency.

Pharmacy Name: Phone:

PRESENTING ISSUES:

Please explain why you have chosen to seek counseling and/or medication evaluation at this time:

What illnesses or surgeries have you had in the past?

Do you exercise? ◯ Yes ◯ No If yes, how much per week? What do you do?

Do you smoke? ◯ Yes ◯ No How long have you smoked?

How much do you some per day?

How would you rate your health? ◯ Poor ◯ Fair ◯ Good ◯ Excellent

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BEHAVIOR – CIRCLE ANY OF THE FOLLOWING BEHAVIORS THAT APPLY TO YOU:

Overeat	**Suicidal attempts**	**Can't keep a job**	**Take drugs**	**Compulsions**
Insomnia	**Vomiting**	**Smoke**	**Take too many risks**	**Odd behavior**
Withdrawal	**Lack of motivation**	**Drink too much**	**Nervous tics**	**Eating problems**
Work too hard	**Procrastination**	**Sleep disturbance**	**Crying**	**Impulsive reactions**
Phobic avoidance	**Outbursts of temper**	**Loss of control**	**Aggressive behavior**	**Concentration difficulties**

FEELINGS – CIRCLE ANY OF THE FOLLOWING FEELINGS THAT APPLY TO YOU:

Angry	**Guilty**	**Unhappy**	**Annoyed**	**Happy**	**Bored**	**Sad**
Conflicted	**Restless**	**Depressed**	**Regretful**	**Lonely**	**Anxious**	**Hopeless**
Contented	**Fearful**	**Hopeful**	**Excited**	**Panicky**	**Helpless**	**Optimistic**
Energetic	**Relaxed**	**Tense**	**Envious**	**Jealous**	**Other:**	_____

PHYSICAL – CIRCLE ANY OF THE FOLLOWING SYMPTOMS THAT APPLY TO YOU:

Headaches	**Stomach trouble**	**Skin problems**	**Dizziness**	**Tics**
Dry mouth	**Palpitations**	**Fatigue**	**Bumping or itchy skin**	**Muscle spasms**
Twitches	**Chest pains**	**Tension**	**Back pain**	**Rapid heart beat**
Sexual disturbances	**Tremors**	**Unable to relax**	**Fainting spells**	**Blackouts**
Bowel disturbances	**Hear things**	**Excessive sweating**	**Tingling**	**Watery eyes**
Visual disturbances	**Numbness**	**Flushes**	**Hearing problems**	**Don't like being touched**

How long have these issues existed? (# of weeks, months, years)_____

Is there anything that you think may have led up to your current difficulties:_____

_____

Please indicate your birth family's medical and psychiatric history below:

Health Issue	**Birth Mother**	**Birth Mother's Family**	**Birth Father**	**Birth Father's Family**	**Siblings (who?)**	**Other Relatives (who?)**
Allergies						
Asthma/Emphysema						
Diabetes						
Heart Condition						
Mental Retardation						
Seizure Disorder						
Depression						
Schizophrenia						
Other Psychiatric						

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Illness						
Trauma/PTSD						
Learning Disability						
Behavioral Problems						
Alcohol Abuse						
Drug Abuse						
Other Illness (Explain)						

MEDICAL INFORMATION:

Primary Care Physician:_____ Tel#:_____

Date of last physical:_____ Date of next appointment:_____

X	Symptoms/Concern	For How long?	Are you receiving Treatment for this Problem? Explain:
	Frequent or Severe Headaches		
	Dizziness/Vertigo		
	Convulsions or Seizures		
	Hypertension		
	Vision Problems		
	Hearing Problems		
	Smelling or Taste Problems		
	Thyroid Problems		
	Persistent Cough		
	Chest Pain		
	Shortness of Breath/Asthma		
	Chronic Fatigue		
	Sleep Disturbance		
	Nausea/Vomiting/Diarrhea		
	Abdominal Pain		
	Constipation		
	Urinary Problems		
	Arthritis		
	Diabetes		
	Obesity		
	Walking/Movement Problems		
	Other:_____		

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List any medications you are currently taking for medical and psychiatric purposes:

Medication	Dosage (mg)	Prescribed by	Reason?	How long on this Med?	Positive or Negative Responses?

Are you allergic to any medications? ◯ Yes ◯ No Please list:_____

_____

SUBSTANCE ABUSE/GAMBLING HISTORY: ◯ Yes ◯ No

Substance	**Date of last use**	**Age of first use**	**Method of Use**	**Amount/Frequency of use**	**Type**
Alcohol					
Marijuana					
Tobacco					
Cocaine					
Crack					
Heroin					
Sedatives					
Amphetamines					
Prescription drugs					
Internet					
Video games					
Other:					

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Have you ever:

Lost a job, become disorderly, fought, or got into trouble while using substances	◯ Yes	◯ No
Consider yourself to have an addiction	◯ Yes	◯ No
Lost friends or relationships due to your addiction	◯ Yes	◯ No
Attended AA, NA, or other self-help groups	◯ Yes	◯ No
Tried to quit using alcohol, drugs, internet, or video games	◯ Yes	◯ No
Felt that you needed substance abuse treatment	◯ Yes	◯ No
Been referred to substance abuse treatment before (when? _____)	◯ Yes	◯ No
Borrowed money in order to gamble or cover lost money	◯ Yes	◯ No
Thought you might have a gambling problem or been told that you might	◯ Yes	◯ No
Been untruthful about the extent of your gambling, or hid it from others	◯ Yes	◯ No
Tried to stop or cut back on how much or how often you gamble	◯ Yes	◯ No
Tried to quit smoking (Tobacco)	◯ Yes	◯ No
Are you interested in receiving help to quit smoking now	◯ Yes	◯ No

PSYCHIATRIC TREATMENT:

Are you currently receiving outpatient services, please indicate services below?

X	Type of Psychiatric Service:	Name/Tel#: of Clinician/Clinic	Starting Date:
	Medication Management		
	Individual Therapy		
	Group Therapy		
	Family Therapy		
	Day Treatment		
	Residential		
	Other:		

If you have previously seen a counselor or psychiatrist/prescriber before, please describe below:

Dates of Treatment	Name/Tel # of Clinician:	Describe Symptoms Treated:

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If you have ever been hospitalized for psychiatric symptoms, please describe below:

Dates of Treatment	Name of Hospital	Describe Symptoms Treated:

Do you have a personal or family history of domestic violence, physical/emotional/sexual abuse or neglect? ◯ Y ◯ N

Please explain:_____

_____

_____

Have you or your family received counseling or other services to address the above abuse or neglect? ◯ Y ◯ N

Please describe (include dates):_____

_____

SOCIAL HISTORY

Marital Status: ◯ Single ◯ Married ◯ Separated ◯ Divorced ◯ Live with Significant Other ◯ Widowed

# of marriages:_____ Length of current marriage/relationship:_____ Length of previous Marriages:_____

If widowed, date and cause of spouse's death:_____

_____

With whom do you spend most of your time?_____

What are your hobbies and interests?_____

Current Living Situation: ◯ Rent ◯ Own ◯ Other (explain?)_____

How long at this residence?_____ Who lives with you?_____

If you have living children, how many? Birth Children___ Adopted Children:____Step Children:_____Other:__

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Deceased children? ◯ Yes ◯ No Please explain (include date/circumstances)_____

_____

# of pregnancies:_____ # of incomplete pregnancies:_____

Date/circumstances of incomplete pregnancies:_____

Psychological or medical issues for living children? Please list below:

Name of child	Age	Diagnosis	Date of Diagnosis	Receiving treatment?

Do your children currently or historically have behavioral problems? Please explain (include police involvement if applicable):_____

_____

Is there DCF involvement? ◯ Yes ◯ No Please explain (indicate length of involvement):_____

_____

DSS Office:_____ DSS Worker:_____ Phone:_____

EDUCATION

Graduated from: ◯ High School ◯ College ◯ Graduate School ◯ Doctorate Program ◯ Job Training

◯ Other (certification, GED):_____

Do you have an interest in pursuing educational opportunities? ◯ Yes ◯ No Explain:_____

Are current psychiatric or medical issues interfering with your ability to go to school? ◯ Yes ◯ No

Explain:_____

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VOCATIONAL HISTORY

Are you currently employed: ◯ Yes ◯ No If yes, where?_____

How long have you been employed there?_____ What is your current position?_____

How many hours do you work each week?_____Do you enjoy this job? ◯ Never ◯ Occasionally ◯ Usually

Describe your relationship with your current supervisor/boss? ◯ Difficult ◯ Manageable ◯ Enjoyable

If not employed, for how long?_____ Reason for Unemployment:_____

Who was your last employer?_____ How long were you there?_____

What was your position?_____Why did you leave?_____

Have you ever served in the Military? ◯ Yes ◯ No Branch:_____Discharge Status:_____

Describe work history: ◯ Consistent ◯ Irregular/Sporadic ◯ Frequent Job Loss ◯ Numerous Jobs

Are current psychiatric or medical issues interfering with ability to work ? ◯ Yes ◯ No

Please explain:_____

Financial Status: ◯ Comfortable ◯ Some Stress ◯ Severe stress

Is there anything else that would be important for WBH to know in order to best meet your clinical needs?

_____

_____

_____

_____

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Please bring this completed form with you on the day of your appointment.
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