

**GREAT BAY MENTAL HEALTH ASSOCIATES, INC.**  
**311 ROUTE 108**  
**SUITE 204**  
**SOMERSWORTH, NH 03878**  
**1 (603) 742-9200**

To Whom It May Concern:

Enclosed, please find the following:

- **Patient Information sheet-to be signed by both parents.**
- **Biographical Information sheet**
- **Symptom Checklist**
- **Patient Agreement**
- **New Hampshire Notice Form**
- **Patient Signature Page-to be signed by both parents and all children 12 or older.**
- **Authorization Form**

It is important that these forms are completed and brought to the office on the day of your scheduled appointment. You will need to arrive for your appointment at least 10 minutes early. The patient agreement and New Hampshire notice form must be read and signed, prior to meeting with the therapist. We also ask that you bring your insurance card, so we may make a copy for our records. We request that you complete the enclosed Authorization for Release of Information so your provider may coordinate care with your primary care physician. If you have any questions, please call the office.

While we make every attempt to call and remind you of an upcoming appointment, this is done as a courtesy only. We are not always able to do this so please be sure to do whatever is necessary to remember and keep your scheduled appointments in order to avoid a charge.

Thank You.

Sincerely,

Secretary of GBMHA Enclosures

**NEW PATIENT INFORMATION SHEET**

Referred by: \_\_\_\_\_ Referred to: \_\_\_\_\_

**Problem to be addressed:** \_\_\_\_\_

Prior treatment (hospital/ outpatient) \_\_\_\_\_

Current medications \_\_\_\_\_

Special Needs (appt. time/ therapist): \_\_\_\_\_

Existing Therapist: \_\_\_\_\_ Family Physician: \_\_\_\_\_

**General Information**

**Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ **Social Security Number:** \_\_\_\_\_

**Mailing Address:** \_\_\_\_\_

**Physical Address:** \_\_\_\_\_

**Telephone number: (H)** \_\_\_\_\_ **(W)** \_\_\_\_\_

**(Cell)** \_\_\_\_\_ **(Other)** \_\_\_\_\_

**Preferred Confirmation Call Contact Name & Number** \_\_\_\_\_

**Emergency contact:** \_\_\_\_\_ **phone number** \_\_\_\_\_

**Billing Information**

Responsible Party Information (if different from patient)

**Name:** \_\_\_\_\_ **Relation to patient:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Phone#:** \_\_\_\_\_

**Subscriber Date of Birth:** \_\_\_\_\_ **Social Security Number:** \_\_\_\_\_

**Insurance Company:** \_\_\_\_\_ **Phone #:** \_\_\_\_\_

**Subscriber Name:** \_\_\_\_\_ **Employer:** \_\_\_\_\_

**Policy Number:** \_\_\_\_\_ **Group Number:** \_\_\_\_\_

**Managed Care Authorization Number:** \_\_\_\_\_

**Patient Agreement**

I have received the Outpatient Services Agreement, which describes the policies of the office and the professional responsibilities of the staff. I understand that I am encouraged to discuss any information addressed in this publication with my doctor or therapist. I authorize Great Bay Mental Health Associates, Inc. (GBMHA), to release any or all information to process my insurance claim, INCLUDING DRUG/ ALCOHOL INFORMATION AND COMMUNICATIVE DISEASES (initial here) \*\* \_\_\_\_\_ \*\*

Insurance claims are sent electronically. If you don't want your claims sent this way, let us know and you can pay at the time of service or submit claims to the insurance company yourself.

I authorize payment of insurance to be made directly to GBMHA, Inc. and acknowledge that I am responsible for any balance not covered by insurance. I AM RESPONSIBLE FOR PAYING FOR A MISSED APPOINTMENT OR ONE CANCELED WITHOUT 24 HOUR NOTICE.

I understand that in order to enhance the quality of care and provide continuity of services, relevant case information may at times need to be shared with other practice clinicians.

**Signature of patient or responsible party:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Signature of patient or responsible party:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**BIOGRAPHICAL INFORMATION- CHILD**

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Address: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Address: \_\_\_\_\_

Marital Status of Parents : \_\_\_\_\_

Do biological parents live together?: Yes  No  Are the parents divorced? Yes  No

If parents are separated or divorced, is there a custody agreement concerning who may make decisions for medical care? \_\_\_\_\_

Joint custody? Yes  No  Joint custody with provisions? Yes  No

If yes, please explain special provisions: \_\_\_\_\_

Are parental rights limited or terminated for either parent by court order? Yes  No

How? \_\_\_\_\_

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**Siblings:**

<u>Name</u>	<u>Age</u>
_____	_____
_____	_____
_____	_____

**Others Living with the Family:**

<u>Name</u>	<u>Age</u>
_____	_____
_____	_____
_____	_____

What brings you to our practice today?: \_\_\_\_\_

Onset of these problems: \_\_\_\_\_

Any previous psychological treatment for child or other family member: \_\_\_\_\_

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Developmental History

How would you describe the pregnancy with your child?: \_\_\_\_\_

Full term: Yes \_\_\_\_\_ No \_\_\_\_\_ Complications: \_\_\_\_\_

What age did your child: Crawl \_\_\_\_\_ Walk \_\_\_\_\_ Talk \_\_\_\_\_  
Toilet train \_\_\_\_\_ Highlight complications \_\_\_\_\_

How did your child separate for daycare or school \_\_\_\_\_

How long did it take to adjust to separation \_\_\_\_\_

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School History

Current School: \_\_\_\_\_

Special Education or Special Needs student: Yes \_\_\_\_\_ No \_\_\_\_\_

Explain: \_\_\_\_\_

Does the child have an Individual Education Plan, or is he/ she coded? \_\_\_\_\_

How would you describe current progress: \_\_\_\_\_

How would you describe past school behavior and progress: \_\_\_\_\_

Is the child frequently absent from school? \_\_\_\_\_ If yes, please explain: \_\_\_\_\_

Please highlight special achievements or problems in elementary school: \_\_\_\_\_

In middle school: \_\_\_\_\_

In high school: \_\_\_\_\_

Has the child skipped any grades? \_\_\_\_\_

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Medical History

Is the child currently under the care of a doctor? \_\_\_\_\_

Pediatrician/ Family Practitioner: \_\_\_\_\_

Any history of medical problems: \_\_\_\_\_

Onset of medical problem: \_\_\_\_\_

Any significant medical problems of other family member(s): \_\_\_\_\_

Any hospitalizations (explain): \_\_\_\_\_

Would you approve of me sharing information with your doctor? Yes \_\_\_\_\_ No \_\_\_\_\_

Is the child presently taking medications? Yes \_\_\_\_\_ No \_\_\_\_\_

Names of medications and dosages: \_\_\_\_\_

How long has the child been taking the medications? \_\_\_\_\_

Allergies: \_\_\_\_\_

Problem / Symptom checklist

- |   |  |
|---|--|
| <input type="checkbox"/> Withdrawn at home & with peers           | <input type="checkbox"/> Alcohol/ drug abuse                     |
| <input type="checkbox"/> Isolated                                 | <input type="checkbox"/> Attention difficulty                    |
| <input type="checkbox"/> Irritable                                | <input type="checkbox"/> Tics or unusual movements               |
| <input type="checkbox"/> Can't settle down                        | <input type="checkbox"/> Overly aggressive- hits or bites others |
| <input type="checkbox"/> Self- critical                           | <input type="checkbox"/> Stealing- inside or outside home        |
| <input type="checkbox"/> Sleep problem                            | <input type="checkbox"/> Bedwetting- after being fully trained   |
| <input type="checkbox"/> Nightmares                               | <input type="checkbox"/> Poor personal hygiene                   |
| <input type="checkbox"/> Sudden drop in school grades             | <input type="checkbox"/> Unusual beliefs                         |
| <input type="checkbox"/> Sudden change of friends sexual problems | <input type="checkbox"/> Unusual fears                           |
| <input type="checkbox"/> Sexual/ physical abuse                   | <input type="checkbox"/> Other _____                             |

Is there any important information you want me to know that we have not asked? \_\_\_\_\_

\_\_\_\_\_

What goals do you have for your child and/ or family? \_\_\_\_\_

\_\_\_\_\_

What would you most want to see happen from this treatment? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Name:

Date:

**SYMPTOM CHECKLIST**

Please check the column that best describes how frequently you have experienced each of the symptoms below. Use the last column to notate the 3 symptoms that bother you the most.

	NEVER	SELDOM	SOMETIMES	VERY OFTEN	Note with an * the 3 most bothersome
Depressed mood					
Intense fears (planes, heights, elevators, etc.)					
Unwanted thoughts					
Doing things over and over					
No memory for blocks of time					
Hearing things not there					
Seeing things not there					
Suspiciousness					
Difficulty sleeping					
Eating difficulty					
Difficulty concentrating					
Reduced/excessive sex drive					
Anxiety					
Feeling panicky					
Frequent nightmares					
Wanting to harm yourself					
Difficulty with memory					
Excessive picking/scratching					
Unusually high energy					
Sexual dysfunction					

	NEVER	SELDOM	SOMETIMES	VERY OFTEN	Note with an * the 3 most bothersome symptoms
Excessive drug/alcohol use					
Tremors					
Fear of social situations					
Fear of being overweight					
Vomiting/purging					
Uncontrollable temper					
Aggressive impulses					
Flashbacks					
Excessive risk taking					
Self-injurious behavior					
Disorientation					
Impulsivity					
Low energy					
Low self-esteem					
Mood swings					
Premenstrual symptoms					
Fear of leaving home					
Problems with partner					
Fear of dying					
Physical pain					
Fear of being sick					
Feeling detached from others					
Addictive behavior					
Feeling uneasy in public					
Other: list below					

**SIGNATURE PAGE/TREATMENT CONTRACT FOR MINORS**

Patients under 18 years of age and their parents should be aware that the law allows parents to examine their child's treatment records unless I decide that such access is likely to injure the child, or we agree otherwise. If the treatment is for substance abuse, parents may only examine the records of a child under age 12. In limited circumstances, a minor may be able to withhold parental access through a Court Hearing. Should you pursue this, we encourage you to seek legal advice.

**Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is sometimes my policy to request an agreement from parents that they consent to limit their access to their child's records.** If they agree, during the treatment, I will provide them only with general information about the progress of their child's treatment, and his/her attendance at scheduled sessions. I will also provide parents with a summary of their child's treatment when it is complete.

Any other communication will require the child's authorization, unless I feel the child is in danger or is a danger to someone else, in which case I will notify the parents of my concern. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have.

**Parent(s)/legal guardian(s) agree to limit their access to my/our child's clinical information except in these situations:** \_\_\_\_\_

**SIGNATURE OF PATIENT** \_\_\_\_\_ **DOB** \_\_\_\_\_ **DATE** \_\_\_\_\_

1. I UNDERSTAND IT IS IN MY CHILDS BEST INTEREST FOR BOTH PARENTS TO
2. PARTICIPATE IN AND GIVE CONSENT FOR TREATMENT.

**PARENTS/LEGAL GUARDIANS:** \_\_\_\_\_ **DATE** \_\_\_\_\_

\_\_\_\_\_ **DATE** \_\_\_\_\_

2. I HAVE RECEIVED THE HIPAA PRIVACY POLICY (NH NOTICE FORM)

**PARENTS/LEGAL GUARDIANS** \_\_\_\_\_ **DATE** \_\_\_\_\_

\_\_\_\_\_ **DATE** \_\_\_\_\_

3. I HAVE READ AND ACCEPT THE OUTPATIENT SERVICES AGREEMENT

**PARENTS/LEGAL GUARDIANS** \_\_\_\_\_ **DATE** \_\_\_\_\_

\_\_\_\_\_ **DATE** \_\_\_\_\_

4. I understand the office policy for **MISSED APPOINTMENTS** and that I will be responsible for up to the full session fee if I do not provide 24 office hours notice of cancellation.

**PARENTS/LEGAL GUARDIANS** \_\_\_\_\_ **DATE** \_\_\_\_\_

**PARENTS/LEGAL GUARDIANS** \_\_\_\_\_ **DATE** \_\_\_\_\_

**SIGNATURE OF THERAPIST** \_\_\_\_\_ **DATE** \_\_\_\_\_

## NEW HAMPSHIRE NOTICE FORM

### Notice of Psychologists' Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

#### I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may use or disclose your protected health information (PHI), for treatment, payment, and health care operations

purposes with your consent. To help clarify these terms, here are some definitions:

- "PHI" refers to information in your health record that could identify you.
- "Treatment, Payment and Health Care Operations"
  - *Treatment* is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.
  - *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
- *Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "Use" applies only to activities within my [office, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "Disclosure" applies to activities outside of my [office, clinic, practice group, etc.], such as releasing, transferring, or providing access to information about you to other parties.

#### II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. "Psychotherapy notes" are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI. You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

#### III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If I have a reason to suspect that a child has been abused or neglected, I am required by law to report this to the Bureau of Child and Family Services.
- **Adult and Domestic Abuse:** If I suspect or have a good faith reason to believe that any incapacitated adult has been subject to abuse, neglect, self neglect or exploitation, or is living in hazardous conditions, I am required by law to report that information to the Commissioner of the Department of Health and Human Services.
- **A. Health Oversight:** If the New Hampshire Board of Psychological Examiners is conducting an investigation, then
  - I am required to disclose your mental health records upon receipt of a subpoena from the Board.
- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about the professional services that I provided you and/or the records thereof, such information is privileged under state law, and I may not release information without your written authorization, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court-ordered. You will be informed in advance, if this is the case.
- **Serious Threat to Health or Safety:** If you have communicated to me a serious threat of physical violence against a clearly identified or reasonably identifiable victim or victims, or if you have made a serious threat of substantial damage to real property, I am required by law to take reasonable precautions to provide protection from such threats by warning the victim or victims of your threat and to notify the closest police department. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court-ordered. You will be informed in advance, if this is the case.

- **Serious Threat to Health or Safety:** If you have communicated to me a serious threat of physical violence against a clearly identified or reasonably identifiable victim or victims, or if you have made a serious threat of substantial damage to real property, I am required by law to take reasonable precautions to provide protection from such threats by warning the victim or victims of your threat and to notify the police department closest to your residence or the potential victim's residence, or obtain your civil commitment to the state mental health system.

#### **IV. Patient's Rights and Psychologist's Duties**

##### **Patient's Rights:**

- *Right to Request Restrictions* - You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* - You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address.)
- *Right to Inspect and Copy* - You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. On your request, I will discuss with you the details of the request process.
- *Right to Amend* - You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.
- *Right to an Accounting* - You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, I will discuss with you the details of the accounting process.
- *Right to a Paper Copy* - You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

##### **Psychologist's Duties:**

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.

#### **V. Complaints**

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact Dr Sandra Rose of G.B.M.H.A., privacy officer. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

#### **VI. Effective Date, Restrictions and Changes to Privacy Policy**

This notice will go into effect on April 14, 2003.

I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice by written notice through the mail.

Revised April 14, 2003