



# Boston Evening Therapy Associates

Patient Demographics and Insurance Information

Boston Evening Therapy Associates, LLC  
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(617) 738-1480  
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info@bostoneveningtherapy.com

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Male  Female  Transgender

Social Security Number: \_\_\_\_\_

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

City/State/Zip: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Other phone: \_\_\_\_\_

Email address: \_\_\_\_\_

Preferred means of Communication:  Cell  Call Work  Call Home  Email

Primary Care Physician: \_\_\_\_\_ Office Phone: \_\_\_\_\_

Who Referred you to Boston Evening Therapy: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship: \_\_\_\_\_

Primary Insurance Company: \_\_\_\_\_

Name of Insured if Different from Client: \_\_\_\_\_ DOB: \_\_\_\_\_

Insurance ID # \_\_\_\_\_ Group # \_\_\_\_\_

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

City/State/Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Secondary Insurance Company: \_\_\_\_\_

Name of Insured if Different from Client: \_\_\_\_\_ DOB: \_\_\_\_\_

Insurance ID#: \_\_\_\_\_ Group#: \_\_\_\_\_

Patient's Initials: \_\_\_\_\_

Insurance Coverage and Private Pay Fees

I accept certain health insurances as well as private payment for therapy. If we determine that your insurance is one of those which I accept, you must then be able to answer the following questions:

Deductibles:

1. Do you have a deductible which must be met before services are paid for by your insurance?

Yes  No

If so, are Behavioral Health visits included in this deductible?  Yes  No

How much is the deductible? \$\_\_\_\_\_

**After the deductible is met**, do you have a:

Copay:  Yes  No

If yes, how much? \$\_\_\_\_\_

Co-Insurance:  Yes  No

If yes, how much? \$\_\_\_\_\_

Or are visits covered at 100%?  Yes  No

2. If you do not have a deductible, do you have a co-payment and how much is it?

Yes  No \$ \_\_\_\_\_

3. Is the insurance under your name?  Yes  No

If not, what is the name and birth date of the card holder? \_\_\_\_\_

4. Does your insurance require you to call for pre-authorization for visits?  Yes  No

If so, have you called to attain this? \_\_\_\_\_

5. Does your insurance require the therapist to request pre-authorization before your first visit, or authorization after \_\_\_\_\_ visits?

Yes  No

6. Does your insurance limit the number of visits you can have in a calendar year? \_\_\_\_\_

If yes, what is the number limit? \_\_\_\_\_

7. Do you have out-of-network benefits if BETA does not accept your insurance?

Yes  No

## **Notice of Privacy Practices, Informed Consent and Therapy Agreement**

### Release of Information to Insurance Company

I authorize the use of disclosure of my individually identifiable health insurance information necessary to process insurance claims. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or healthcare provider, the released information may no longer be protected by federal privacy regulations.

### Notice of Privacy Practices and Informed Consent

The following information provides an overview of the services provided to you by BETA as a Psychologist, Licensed Independent Clinical Social Worker, or Licensed Mental Health Clinician and serves as an agreement between the provider and you (the client). Please read the following points carefully and make notes or questions you have for our next session. Periodically you may review this agreement with your mental health professional at any time as the therapeutic process deepens.

### Services

Counseling is a relational process that requires the participation of you (the client) and your mental health professional. The work together is based on clinical training as well as your immediate concerns and needs (including your spiritual and religious orientation, if you choose). Our intent is to help you to strengthen your relationship with yourself and others, as well as to help you address a variety of life's challenges.

### Risks of Counseling

Counseling requires a commitment by yourself and your mental health professional. At times the process of therapy can often surface difficult emotions and memories including fear, anger, sadness, and grief. These feelings are healthy and can lead to greater understanding and freedom to express our true selves and to live a life of purpose and meaning. In the event that these feelings become too difficult to manage, please inform your mental health professional and, depending on your particular circumstances, additional face-to-face sessions will be scheduled.

### Contact Information

Your mental health professional is available by telephone (phone number is on their business card), if needed. Messages are generally checked each weekday and usually returned as soon as possible. If unavailable for an extended time, a message stating this will be on the answering machine. If you are currently working with one of our professionals, they will inform you personally. In an emergency, please dial 911 and go to the nearest hospital emergency room. We also communicate via email and text messaging to set up appointments only. We will not discuss your treatment via email or text messaging to protect your privacy and rights.

### Confidentiality

All sessions will be kept between you (the client) and your mental health professional. Legally, we are unable to discuss our sessions with anyone with the following exceptions:

**1) You are planning to hurt yourself or someone else. These actions may include: Your mental health professional notifying a potential victim, contacting the police, or seeking hospitalization for you, the client.**



**Authorization to Use Credit Card for Psychotherapy Services**

**I authorize Boston Evening Therapy Associates, LLC (BETA) to charge my credit card for the sole purpose of psychotherapy, consulting or counseling services rendered.**

**I authorize BETA to use my credit card or HSA card exclusively for costs incurred or outstanding as a result of psychotherapy including the following: insurance copayments, unmet insurance deductibles, missed or late cancellations of appointments.**

**Missed Appointments with less than 24 hrs notice in the amount of: \$165**

**Amount to be charged: \$ \_\_\_\_\_**

**Patient Name (please print) \_\_\_\_\_**

**Patient's Zip Code where you receive your credit card statement \_\_\_\_\_**

**Credit Card:  VISA  MASTERCARD  AMERICAN EXPRESS**

**Credit Cd#: \_\_\_\_\_**

**Exp. date: \_\_\_\_\_**

**3 digit code \_\_\_\_\_**

**Cardholder's Name (Please Print): \_\_\_\_\_**

**Signed: \_\_\_\_\_ Date: \_\_\_\_\_**

**Therapist Name (Please Print): \_\_\_\_\_**

**Signed: \_\_\_\_\_ Date: \_\_\_\_\_**