Jennifer D. Lish, Ph.D.

Worcester Center for Cognitive Behavior Therapy
9 Cedar Street, Worcester, MA 01609
508-210-0114

Welcome.
Prior to your first appointment, please complete the attached forms.

First Name_____ Initial____Last Name_____

Address:_____

City/Town: _____State _____Zip Code_____

Date of Birth_____ Social Security Number_____

Occupation_____Place of employment_____

Home Phone_____Work Phone_____

Cell phone_____E-Mail_____

Name of Subscriber to Health Insurance_____

Subscriber's Social Security Number_____

May Dr. Lish leave confidential messages (ie, appointment reminders) on your answering machine or voicemail? ___Y ___N

How did you hear of us?_____

Sex: ___F ___M Marital status: __Married __Widowed __Divorced __Never married __Domestic Partner _N/A

Others in your family:

Name	Relationship	Age
1.		
2.		
3.		
4.		
5.		

Your Medical conditions:

._____

._____

._____

._____

Surgeries/hospitalizations (other than for childbirth):

_____

._____

._____

Medications, vitamins, supplements taken regularly (name, dosage, when started):

._____

._____

._____

Other current or past mental health or substance abuse treatment (year, name of provider, address, telephone number)

._____

._____

._____

Please list a family member or other persons, if any, whom Dr. Lish may contact ONLY IN AN EMERGENCY.

Emergency Contact:_____ **Emergency Phone:**_____

Signed: _____ **Date**_____

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First Name: _____ Init:_____ Last Name_____

Date of birth_____

I give permission to Dr. Jennifer Lish to exchange information about my medical history with the organizations or individuals listed below:

Primary care physician (name and phone number):

_____

Other/Past Mental health care providers (name and phone number)

_____

_____

Family member (name and phone number)

_____

School (name and phone number)

_____

Other (name and phone number)

_____

This includes my diagnosis and/or treatment related to mental health, psychiatric care, alcohol abuse or substance abuse. The purpose of this release is to allow the individuals or organizations to assure continuity and coordination of care among my health care providers. If there are any limitations about the release of information, they are written here:

_____

I may cancel this agreement at any time except if the information has already been released. If not cancelled, this agreement will end one year from the date written below.

_____ _____

(Signature of patient or parent/guardian) **(Date)**

To person receiving released information: This information has been disclosed to you from records protected by Federal confidentiality rules (42CFR, Part2) the Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR, Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of this information to criminally investigate or prosecute any alcohol or drug abuse patient.

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TREATMENT CONTRACT

Telephone contact information: If you need to contact Dr. Lish, please telephone 508-210-0114. In case of life-threatening emergency, do not attempt to reach Dr. Lish, but call 911 or proceed to your nearest hospital emergency room immediately. Emergency mental health treatment may also be sought twenty-four hours per day every day of the year at Emergency Mental Health Services, University of Massachusetts Memorial Healthcare Center, 55 Lake Avenue, Worcester, MA (508-856-3562).

Payment: Fees will be billed to the patient's medical insurance company. Payment of co-insurance, co-payments and deductible is the responsibility of the patient. Payment is due at the time of service. Payment may be made by cash, debit card, or credit card. Fees are as follows:

Initial evaluation (45 minutes): $275.00
Psychotherapy sessions (45 minutes): $175.00

If you have Blue Cross Blue Shield health insurance, these fees should ordinarily be paid by your health insurance company, with the exception of any co-payment, coinsurance or deductible. If you have other health insurance, or Blue Cross Blue Shield declines to pay for your treatment, payment is your responsibility.

Cancellation policy: Please schedule your sessions at times when you are certain you will be able to attend. Please arrange your other obligations so as to ensure that you will be able to attend all scheduled appointments. This time has been reserved for you far in advance and therefore not offered to other individuals who could make use of it. It is generally not practical to reschedule appointments. Dr. Lish can receive payment from your health insurance company only if you attend the session. Sessions should not be cancelled or rescheduled except in unusual circumstances. If you cancel with at least 48 hours notice, it may be possible to offer your time to another individual. If you no-show or cancel with less than 48 hours notice, you will be charged a $150.00 fee that cannot be recovered from your medical insurance company. Exceptions are made to this policy only in case of severe personal illness or injury, hospitalization, death of a family member, or snow or ice storms that make it impossible to travel safely. If you must cancel your session please call Dr. Lish at 508-210-0114.

Organizational affiliations: Dr. Lish is part of a group of independent mental health professionals named the Worcester Center for Cognitive Behavior Therapy. This group is an association of independently practicing professionals who shares certain expenses and administrative functions. Although the members share a group name and an office space, Dr. Lish is completely independent in providing you with clinical services and Dr. Lish alone is fully responsible for those services. Dr. Lish' professional records are separately maintained. No other member of the group has access to Dr. Lish's records without your specific, written permission, except in case of a clinical emergency. There is another association of independent mental health professionals named Cedar Associates located at the same address. However, Dr. Lish has no association with Cedar Associates. Your treatment is being provided solely by Jennifer D. Lish, Ph.D., a psychologist in private practice, not by any other entity.

Confidentiality: As a licensed psychologist, Dr. Lish is bound by the ethical codes of the American Psychological Association, by the laws of the Commonwealth of Massachusetts, and by federal laws, including the law known as HIPAA, regarding the confidentiality and privacy of medical information. These laws require Dr. Lish to keep all information obtained from you completely private and confidential with the following exceptions:

1. If Dr. Lish has reason to believe that there is significant risk of you harming yourself or others Dr. Lish is required to disclose information as needed to ensure your safety and the safety of others.

2. If Dr. Lish has reason to believe that any person under age 18, any person over age 60, or a developmentally disabled person between the ages of 18 and 60 has been being abused or neglected Dr. Lish is required to make reports to relevant state agencies. Psychologists are mandated reporters to the Division of Child and Family Services (DCF).

3. Dr. Lish can be compelled by a judge to testify in a court of law. This occurs rarely, and primarily in proceedings regarding the custody of children.

4. Dr. Lish will communicate with other individuals who have provided healthcare to you (e.g. your primary care practitioner, other physicians and other mental health professionals) if you give specific written consent. If you decline to give this consent, this may negatively impact the quality of the care provided to you.

5. If you are under age 18, Dr. Lish will communicate some information to your parents or legal guardians. The nature of these communications will be discussed in more detail with you at the initiation of your treatment.

6. Dr. Lish will communicate clinical information to your health insurance company in order to secure payment for your care. If you wish to forbid this communication, please communicate this in writing to Dr. Lish. This may limit the amount of financial coverage that your health insurance company will provide for your care.

7. Dr. Lish will sometimes seek case consultation with other mental health and medical professionals in order to improve the quality of the care rendered to you. In these case consultations, Dr. Lish will not reveal your name or any other identifying information. These other professionals are similarly bound by laws regarding confidentiality and privacy.

8. If you are over age 18, Dr. Lish may communicate information regarding your treatment with other entities (family members, etc.) only with your specific written consent on a separate form.

I have read this consent form, had the opportunity to ask questions, and received a copy for my records. I consent to the above policies.

Specifically, I consent to pay a fee of $150.00, which cannot be recovered from my medical insurance company, for any sessions cancelled with less than 48 hours notice, with the exception of cancellations caused by severe personal illness, family deaths, or weather conditions that prevent safe travel.

_____

(Signature of patient or parent/guardian) **(Name)** **(Date)**