Be Well and Beyond Inc.
integrated health options for mind and body

77 Great Road, Suite 203
Acton, MA 01720
Phone: 978-263-5771/ Fax: 978-263-5778
info@bewellandbeyond.com

PATIENT INFORMATION

Patient Name: _____ **Date of Birth:** _____
Address: _____ **Home Phone:** _____
City/State/Zip: _____ **Cell Phone:** _____

Primary Care Physician: _____

Responsible Party for Insurance Payment
Name (if different from above): _____ **Date of Birth:** _____
Address: _____
City/State/Zip: _____ **Phone:** _____
Relationship to Patient: _____
Primary Insurance Company: _____
Insurance ID: _____
Co-Payment Information: _____

Financial Policy:
Appointments cancelled with less than 24-hour notice will be charged to me at the full hourly fee. Secondary Insurance will be billed as a courtesy. However, I am responsible for the entire balance of services performed (regardless of insurance coverage).

I understand and agree to the above-stated financial policy.

_____ _____
Signature **Date**

Release of Information and Assignments of Benefits for Insurance:
I authorize the release of any medical or other information necessary to process insurance claims.

_____ _____
Signature **Date**

I authorize payment of medical benefits to my provider for services performed.

_____ _____
Signature **Date**

Family Data

Member Name	Date of Birth	Occupation	Other Information

Reason for Your Visit Today: _____

Be Well and Beyond, Inc.
Behavioral Health Release of Information Form

Member Information

Name: _____ **Date of Birth:** _____

Insurance: _____ **Insurance ID:** _____

Behavioral Health Provider	**Primary Care Provider**	☐ **State Agency** ☐ **Other** ☐ **Family Member**
Name:	**Name:**	**Name:**
Address:	**Address:**	**Address:**
Phone: **Fax:**	**Phone:** **Fax:**	**Phone:** **Fax:**

I (or I on behalf of) _____

Print Member Name and Address

give permission to the individuals or organizations listed above to exchange information about my medical history. This includes my diagnosis and/or treatment related to alcoholism, substance abuse, mental health, or psychiatric care. This does **NOT** include results of any blood test for HIV antibodies or any other HIV- or AIDS-related information. The purpose of this release of information is to allow the individuals or organizations to assure continuity of care among my health care providers, including carrying out discharge planning arrangements; to carry out utilization review and quality assurance activities; to determine eligibility for benefits; and to make payment decisions.

If there are any limitations about the release of information, they are written here: _____

I may cancel this consent at any time, except to the extent that information has already been released. If not canceled, this consent will expire one year from the date written below. I understand that I do not have to sign this form to receive insurance benefits from the health plan to which I belong.

_____ _____

Signature of Member/Legal Representative or Guardian **Signature of Witness**

_____

Date

☐ I do not authorize the release of information as described above. However, I understand that, if I do not allow my providers to exchange information about me, they will not be able to coordinate my care. I understand that, in an emergency situation, my providers may exchange information about me to the extent allowed by law.

_____ _____

Signature of Member/Legal Representative or Guardian ***Signature of Witness***

_____

Date

Prohibition on Re-Disclosure

***To Person Receiving Released Information*:**

*This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR Part 2) or state confidentiality laws. Federal regulation prevents you from making any further disclosure of substance abuse information without the specific written consent of the person to whom it pertains. A general authorization for the release of medical information is **NOT** sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.*

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NOTICE OF PRIVACY PRACTICE SUMMARY

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

***Be Well and Beyond , Inc*.,** in accordance with applicable federal and state law, is committed to maintaining the privacy of your Protected Health Information (PHI), in other words, information about your health condition and the care and treatment you receive. We will use and disclose elements of your PHI in the following way:

- Treatment
- Payment
- Healthcare Operations
- When release is required by law, including judicial settings, and to health oversight regulatory agencies and law enforcement.
- In emergency situations or to avert serious health/safety situations.
- To medical examiners, coroners or funeral directors to aid in identifying you or to help them in their duties.
- To organ, tissue, and other donation organization, upon or proximate to your death, if we have no indication on hand about your donation preferences.
- Appointment reminders, treatment alternatives, and other related benefits and services.
- Sponsor of Your Health Plan

All other uses and disclosure by us will require us to obtain from you a written authorization in addition to any other permission you will provide us.

YOUR RIGHTS. You have the following rights concerning your PHI:

- **Restrictions** (to request restricted access to all or part of your PHI). To do this, please make this request in writing. We are not required to grant your request.
- **Confidential Communications** (to receive correspondence of confidential information by alternate means or location). To do this, please make a request in writing.
- **Access** (to inspect or to receive copies of your PHI). To do this, please submit a request in writing.
- **Amendment (**to request changes be made to your PHI). To do this, please submit a request in writing.
- **Accounting** (to receive an accounting of disclosure by us of your PHI in the six years prior to your request). To do this, please submit a request in writing.
- **This Notice** (to get updates or reissue of this notice). At your request.
- **Complaints** (to complain to our office or the US Department of Health & Human Services, if you feel your privacy rights have been violated). To register a complaint with us, please submit this request in writing. The law forbids us from taking retaliatory action against you if you complain.

OUR DUTIES. We are required by law to maintain the privacy of your PHI. We must abide by the term of this notice or any update of this notice.

Privacy Contact: To obtain additional information on or have your questions about your rights answered, you may contact ***Be Well and Beyond, Inc*.,** 77 Great Road, Acton, MA 01720.

Effective Date: This notice is in effect as of April 14, 2003. A complete copy of the Notice of Privacy Act is available.

Acknowledgement of Receipt _____ Date_____

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NEW PATIENT CONSENT
TO THE USE AND DISCLOSURE OF HEALTH INFORMATION
(for Treatment, Payment, or Healthcare Operations)

I, _____, understand that as part of my healthcare, **Be Well and Beyond Inc.** originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as

- a basis for planning my care and treatment.
- a means of communication among the many health professionals who contribute to my care.
- a source of information for applying my diagnosis and surgical information to my bill.
- a means by which a third-party payer can verify that services billed were actually provided.
- a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a **Notice of Privacy Practices** that provides a more complete description of information uses and disclosures.

I wish to have the following restrictions to the use or disclosure of my health information:

_____

_____

_____

_____

I understand that as part of this organization's treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax. I further understand that I give permission for providers to communicate in order to coordinate my care and treatment.

By signing this, I fully understand and accept the terms of this consent.

_____ _____

Patient Signature **Date**