Integrity Women's Health
27 College Street, Suite 201
South Hadley, MA 01075
Phone (Dr.Berkman, P.hD): 413-348-5333

PATIENT INFORMATION

Last Name: _____ First: _____

Date of first visit: _____ DOB: _____ Age: _____

Address: _____City/State/ Zip:_____

Phone number: _____ Okay to leave message? Yes □ No □

Alternate phone number: _____

Email: _____ (please list an email you check regularly).

Gender: _____

Married □ Divorced □ Relationship □ Single □

Number of children: _____ Number of pregnancies: _____

Occupation: _____ Employer: _____

Primary Care Physician: _____ Practice Name: _____

EMERGENCY CONTACT: _____ **PHONE:** _____

HEALTH HISTORY

Reason for visit: _____

_____

_____

Have you been in therapy before? Yes □ No □ If yes, when? _____

Have you ever been hospitalized for mental health concerns? **Yes** □ No □

Hospitalization dates: _____

Please list your current medications:

Medication	**Dose**
_____	_____
_____	_____
_____	_____
_____	_____

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Are you currently having suicidal ideation?

Never □ Some of the time □ Frequently □

I would describe my physical health as:

_____

_____

Physical Health Concerns:

_____

_____

Are you struggling with any addictions? Please specify:.

_____

_____

_____

Hobbies and activities I enjoy:

_____

_____

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CONSENT TO TREATMENT

The psychotherapy services of Dr. Deborah Berkman, Ph.D.

This agreement has been designed in order to provide you with a description of the services and therapy that I provide. Please read this thoroughly and ask any questions that you may have. I have provided a space for your initials at each ending and a space for your signature at the end. Because I believe therapy to be a relationship, I, too, will sign this agreement and provide you with a copy.

Consent to Treatment: I, _____(client), hereby consent to receive mental health treatment from Dr. Deborah Berkman, Ph.D. I understand that my consent is voluntary. I also understand that I do not have to accept any treatment option offered and that I may withdraw my consent at any time. _____

Appointments: Each client will have an initial appointment lasting approximately 60minutes. All appointments thereafter will be weekly (unless otherwise discussed) and will be 45 minutes. It is advised that you arrive on time for your appointments as we will end promptly at the 45 minutes before the hour is up. If I should be late to our appointment, I will provide you with your full 45 minutes or attach the remainder of the time to another session as needed.

_____

Fee Schedule:

- Initial Session for an Individual: $150 (60 minutes)
- Follow up session for an individual: $135 (50 minutes)
- Couples Initial Session: $200 (60 minutes)
- Couples Follow-up Session: $150 (60 minutes)
- Insurance copay and deductible will depend on the fee contracted by your insurance company.

Payment:

- You are welcome to pay with check (payable to Integrity Women's Health) or credit card. If you chose to pay with a credit card then Integrity Women's Health will email you an invoice after your session, or when insurance issues an EOB. <u>You can pay online within two days upon receipt of invoice.</u>
- <u>Copays and session fees (the invoiced amount) that are not paid within 3 days of receipt will be charged to the credit card that you provided on your intake form.</u> If at anytime you would like to change the CC on file please tell us and we will provide you with a new credit card form. This will help to insure that there is no disruption in providing you therapy sessions.

Billing Authorization and Release of Information: I hereby authorize Integrity Women's Health (IWH) to bill my insurance company for Dr. Berkman's services and to release my individually identifiable health insurance information necessary to process insurance claims. I

understand that my individually identifiable health insurance information will also be released to IWH's billing service; 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.

_____

Assignment of Benefits: I hereby authorize the payment of my insurance benefits directly to Integrity Women's Health. _____

Phone calls/Availability: If you are needing to reach me outside of our scheduled appointment, you may reach me on my voicemail at 413.348.5333. I check my messages daily and try to return all calls within 24 hours. In a life threatening emergency or if you need immediate attention, you can receive assistance by calling 911, going to your local emergency room, or calling crisis services at 413.774.5411(Franklin County) / 413.586.5555(Hampshire County)_____

Cancellations: Full fee will be charged for missed appointments without 24 hours notice. If you are using insurance, be aware that I cannot bill them for a missed session, so you will be responsible for this cost. Exceptions will be made if you are having an unavoidable emergency. or sudden illness. In the event that I need to cancel or change an appointment, I will honor our appointments with the same courtesy of 24 hours notice unless there is a sudden emergency or illness within my family. If you are expecting to go on vacation, I would request 2 weeks notice so that I may plan my schedule accordingly. I will provide you with the same courtesy in the event that I will be going on vacation. _____

Confidentiality: The work we do together is private except in the following circumstances:

1. when you are risk of harming yourself or someone else.

2. if a child or elderly person is at risk of abuse or neglect.

3. if I am ordered to disclose information via the courts.

In addition, I periodically consult with colleagues to assist me in my work, and to offer advice and ideas. It is with them that I may share some information about your personal situation, leaving out any details that would identify you specifically. Again, this is done to uphold confidentiality.

If we happen to meet outside my office – at a social event or grocery store, for instance - the decision to approach or acknowledge me is up to you. I will not make the first move in order to protect your privacy. You are welcome to greet me, keeping in mind that confidentially becomes more complicated if I am accompanied. To some this may sound a bit extreme; for others this barely covers their need for safety. I feel that privacy is a powerful factor in therapy, so I do my best to maintain it. _____

Therapeutic Relationship: At times in therapy, you may feel somewhat worse. This is very common as you bring up unresolved issues and work through feelings. I encourage you to ask

questions or to raise concerns, whether it be about the therapy itself, fees, scheduling, or anything else that may arise. I have discovered that clients gain the most from their treatment when they freely speak with me about their therapeutic process._____

_____ _____
Signature of Client Date

_____ _____
Signature of Deborah Berkman, Ph.D Date

CREDIT CARD AUTHORIZATION

Credit Card Number: _____

Expiration Date: _____/_____/_____ 3 digit security code: _____

Billing zip code: _____

Name on Card: _____

I authorize Integrity Women's Health to charge this credit card for invoiced amounts that are not paid within 3 days of receiving the initial invoice.

_____ _____
Patient Signature Date