**Allison W. Moreau, LICSW**
**61 Nicholas Road, Suite B4**
**Framingham, MA 01701**
**(781)254-7923**
**allisonwmoreau@yahoo.com**

## PATIENT INFORMATION SHEET

**NAME:** ______________________________________________
**(LAST) (FIRST) (MID)**

**PHONE: (H)** ____________ **(C)** ____________ **(e-mail)** ____________

**ADDRESS:** ______________________________________________

**CITY:** ______________________________________________

**STATE:** ____________ **ZIP:** ____________

**Date of Birth:** ______________________________________________

**Occupation:** ______________________________________________

**Employer:** ______________________________________________

**Legal Status: (circle one): S M Sep D W**

**Emergency Contact:** ____________ **Relationship to Patient:** ____________

**Person to Receive Bill:** ______________________________________________

**Address (If different from above):** ____________ **Phone:** ____________

**Primary Care Physician:** ____________ **Address:** ____________

**HEALTH INSURANCE:**

**State:** ________ **Type of Insurance:** ____________ **Insurance Phone # (benefits):** ____________

**Subscriber Name:** ____________ **ID #:** ____________ **Group #:** ____________

**Subscriber DOB:** ____________ **Subscriber Employer:** ____________

**Subscriber Employer Address:** ______________________________________________

**No Insurance (Circle if applicable)**

**I hereby authorize my insurance benefits to be paid directly to Allison Moreau, LICSW for the medical services rendered. I also authorize to release any information necessary to process this claim.**

**Signature:** ____________ **Date:** ____________

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## STATEMENT REGARDING PRIVATE HEALTH INFORMATION:

Name: ________________________________________________

***It is the intent of this office to be in compliance with the Privacy Standards for Private Health Information (PHI) covered under Health Insurance Portability and Accountability Act (HIPAA).***

- ► I understand that I have the right to request that certain information be excluded from my record unless the information is related to my diagnosis or to one of the exceptions listed in the Statement Regarding Confidentiality.

- ► I understand that I have the right to amend information but not expunge ("erase") information from my record.

- ► I understand that I have the right to inspect and/or receive a copy of my Private Health Information (PHI) i.e. record unless it is legally determined that it would adversely affect my well-being or I am a minor. My request must be fulfilled by this office within 60 days of my written request. There will be a charge for copies.

- ► As additional HIPAA regulations are mandated and clarified, this office will be altering its policies and procedures to be in compliance.

- ► If this office is found to be in violation of the Primary Standards put forth in HIPAA, I am urged to speak with my therapist and if not resolved, I have a right to file a formal compliant with the Office of Civil Liberties.

***I have read and received a copy of the above Privacy Standards for Private Health Information covered under HIPAA.***

Signed: ___________________________________ Date: _________________

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## STATEMENT REGARDING CONFIDENTIALITY:

► I understand that information about my treatment and communications with my therapist is confidential and may not be released without my written authorization. However, these communications or this information may have to be revealed without my permission as per the following exceptions:

. . . Harmful intent or acts:
If you express your planned intention of harming yourself (and cannot contract for safety), or your emotional/mental state is observed by me to put you at risk (In this event, I may seek hospitalization or contact family members or others who can help provide protection).

. . . If you express that you intend to do bodily harm to another person. (In this event, I am obligated by law to take reasonable precautions to ensure others' safety.)

. . . If I believe a minor, elder, or disabled person in your care is suffering abuse or neglect. (In this event, I am mandated by law to report this information to the appropriate authority)

. . . If you are a minor and you share that you are currently or have been physically or sexually abused, or if I determine that you are at significant risk of harm for other reasons e.g. being a witness to domestic violence in your home or being at risk of harm due to a parent or guardian's actions. (In this event, I am mandated by law to report this information to the appropriate authority).

Health care benefits:
. . . Your insurance company requests information relative to payment of your claim; if you are using a third party reimbursement, I am typically required to provide the insurer with a clinical diagnosis (as outlined in the Diagnostic and Statistical Manual of Mental Disorders – DSM-IV), dates of services, and often a treatment plan or summary.

Courts of law:
. . . If I receive a signed order by a judge to testify in court or to provide records. Some examples include:

- If a judge thinks, I, as your therapist, have evidence about your ability to provide care or custody in a child custody or adoption case

- In court proceedings involving the care and protection of children or to dispense with the need for parental consent to adoption
- In a legal proceeding where you introduce my mental or emotional condition
- If you bring an action against me, as your therapist, and disclosure is necessary or relevant to a defense
- If a court orders access to your records in a sexual assault or other criminal case.

Overdue payments:
If your account is overdue and arrangements for payment have not been negotiated, a collection agency may be provided with dates of service, type of service, and total amount due.

Minor under the age of 18:
If you are under 18 years of age, please be aware that your parents have the right to receive general information regarding your treatment and may request a summary of how treatment is proceeding. I will discuss with you and your parent(s) what specific information will and will not be shared.

Consultation with other professionals:
I may occasionally find it helpful to obtain consultation from other professionals concerning a given case. During these consultations, I would make diligent efforts to speak about my clients anonymously to avoid revealing the identity of the client. The consultant would also be bound by confidentiality laws and ethical codes.

I have had the opportunity to discuss this informed consent statement with my therapist. I understand its meaning and consent to receiving services based on this understanding.

Client Signature: _______________________________________ Date: _________________

Client Name (print): _____________________________________

Therapist Signature: ______________________________________ Date: ________________

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# Authorization For Release and Collection of Client Information

To allow Allison Moreau, LICSW to release information to, discuss information with, or receive information from others, please complete this form and return it to Allison W. Moreau, LICSW.

## Client Information

**Client Last Name** ___________________________ **First Name** ____________________________

**Street Address** _____________________________________________________________________

**City** ______________________________________ **State** ____________________ **Zip** ________

**Date of Birth** ______________________________ **Home Telephone** _(____)________________ __

Allison Moreau, LICSW has my permission to release to, discuss with, and/or receive from the person/organization (named below) the following information about the above named client:

**Information (please be specific):** Diagnostic and treatment information

**Restrictions and/or exclusions (if any):** _________________________________________________

**Purpose of release/collections:** Coordination of care and on-going evaluation by telephone, facsimile, written documentation, or meetings if indicated.

Allison Moreau, LICSW will release to, discuss with, and/or collect information from the following party:

**Name** _____________________________________________________________________________

**Street Address** _____________________________________________________________________

**City** ______________________________________ **State** ____________________ **Zip** _______

**Telephone** __(____)___________________________

I herewith release and hold harmless, Allison W. Moreau, LICSW, from any liability for the release of any information provided in accordance with this directive. This may include information about drug or alcohol use, psychiatric, social work, or other protected information unless otherwise excluded, except psychotherapy notes. I am aware that Allison Moreau, LICSW cannot control how the recipient uses or shares the information, and that laws protecting its confidentiality may or may not protect this information once it has been disclosed to the recipient. Information will not be released without a valid signature below. I can however, cancel this authorization in writing at any time.

**This authorization will end (enter date or event):** ________________________________________

___________________________________ _________________________

**Signature of Client** **Date**

___________________________________ ____________________ _________________________

**Signature of Parent or Guardian** **Relationship to client** **Date**

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## CONSENT TO TREATMENT OF A MINOR

Client's Name: _________________________

Date of Birth: _________________________

I, ___________________________________, give my consent to Allison Moreau, LICSW, to provide treatment and therapy necessary or advisable for my child. I understand that I may stop treatment at any time and that Allison Moreau, LICSW has the same right.

I realize that my child's treatment is confidential. Information may not be released without my written consent except in the event that an issue is raised which in the therapist's judgment would endanger my child's welfare. I would be notified, as would appropriate authorities and resources, if indicated. (See "Statement of Confidentiality," policy)

My child's therapist may determine with my child that my participation is needed to treat a specific problem.

_________________________________ _________________________
Signature of Parent/Legal Guardian Date

_________________________________ _________________________
Signature of Child (if indicated) Date