Eunice Aviles, PsyD, LMHC, LPC
2424 Morris Avenue, Suite 103, Union, NJ 07083/57 Mulberry St. Springfield, MA 01105
dr.euniceaviles@euniceaviles.net Phone: (413) 657-6104

Date: _____

Legal Name: _____ Date of Birth: _____ SS: _____

Name: _____ Pronoun: _____

Sex assigned at birth: _____ Gender identity: _____

Address (Street, City, State and Zip Code): _____

_____

Home phone: _____ Can I leave a message? __Yes __No

Cell phone: _____ Can I leave a message? __Yes __No

Work phone_____ Can I leave a message? __Yes __No

Email address _____

*Please note: Email correspondence is not considered to be a confidential medium of communication.

Legal guardian (If applicable)

Name: _____ Phone: _____

Address (Street, City, State and Zip Code): _____

_____

Health Insurance Information (Massachusetts only)

Policyholder insurance company name:	Pre-authorization required? __Yes __No
Policy number:	Benefit verification phone number:
Group number:	Pre-authorization phone number:
Policyholder name:	Pre-authorization confirmation #:
Policyholder DOB:	Number of sessions authorized:
Policyholder employer:	Re-authorization date:
Policyholder address and phone number:	
Secondary insurance policy number: __N/A _____	Secondary insurance benefit verification phone: __N/A _____

Please provide 2 forms of identification such as health insurance card, driver's license, and/or state ID.

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TREATMENT REQUEST AND INFORMED CONSENT
Psychotherapist-Client therapy agreement

Welcome to my practice. Please read the following documents carefully, making sure that you understand everything before you sign. When you sign this document, it will also represent an agreement between us. We can discuss any questions you have when you sign them or at any time in the future.

Psychotherapy services
Eunice Aviles, PsyD, LMHC, LPC, is a Doctor of Clinical Psychology (PsyD), a Licensed Professional Counselor in the state of New Jersey, a Licensed Mental Health Counselor in the state of Massachusetts, a Licensed Psychologist in Puerto Rico and a Sex Therapist certified by the American Association of Sexuality Educators, Counselors and Therapists (AASECT).

Psychotherapy with Eunice Aviles, PsyD, LMHC, LPC may include individual psychotherapy, group psychotherapy, family therapy, couples therapy, sex therapy and/or gender therapy.

You and your Therapist have a professional relationship existing exclusively for therapeutic treatment. This relationship functions most effectively when it remains strictly professional and involves only the therapeutic aspect. Your Therapist can best serve your needs by focusing solely on therapy and avoiding any type of social or business relationship. Gifts are not appropriate, nor are any sort of trade of service for service.

The psychotherapy process is beneficial, but as with any treatment, there are risks. During therapy, you will have discussions about personal situations that could trigger uncomfortable emotions (ex. sadness, anger). The benefits of psychotherapy can far outweigh any discomfort encountered during the process. Therapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems. There are no guarantees about what will happen. Psychotherapy requires a very active effort on your part. In order to be most successful, you will have to work on things we discuss outside of sessions.

Appointments
The first sessions will involve a comprehensive evaluation of your needs. By the end of the evaluation, I will be able to offer you some initial impressions of what our work might include. At that point, we will discuss your treatment goals and create an initial treatment plan. You should evaluate this information and make your own assessment about whether you feel comfortable working with me. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

Appointments will ordinarily be 45-50 minutes in duration, once per week at a time we agree on, although some sessions may be more or less frequent as needed. The time scheduled for your

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appointment is assigned to you and you alone. If you need to cancel or reschedule a session, I ask that you provide me with 24 hours' notice. If you miss a session without canceling, or cancel with less than 24-hour notice, my policy is to collect the full session fee. It is important to note that insurance companies do not provide reimbursement for cancelled sessions; thus, you will be responsible for the fee as described above. If it is possible, I will try to find another time to reschedule the appointment. In addition, you are responsible for coming to your session on time; if you are late, your appointment will still need to end on time.

Insurance (Massachusetts only)
I accept some insurances in Massachusetts, not in New Jersey or Puerto Rico. If I accept your insurance, with your permission, my billing service and I will assist you to the extent possible in filing claims and ascertaining information about your coverage, but you are responsible for knowing your coverage and for letting me know if/when your coverage changes.
You should also be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. Sometimes, I have to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. I will provide you with a copy of any report I submit, if you request it. By signing this Agreement, you agree that I can provide requested information to your carrier if you plan to pay with insurance.

Young adults that are still covered by their parents' insurance should be aware that insurance companies will routinely send information for billing purposes (Ex. Explanation of Benefits). As a result, parents/guardians will find out about treatment.

If I am not a participating provider for your insurance plan, I will supply you with a receipt of payment for services, which you can submit to your insurance company for reimbursement. Please note that not all insurance companies reimburse for out-of-network providers.

Professional fees
The standard fee for the initial intake is $195.00 and each subsequent session is $165.00. You are responsible for paying at the time of your session unless prior arrangements have been made. Payment must be made by check, cash or Ivy (method of payment). Any checks returned to my office are subject to an additional fee of up to $25.00 to cover the bank fee that I incur. If you refuse to pay your debt, I reserve the right to use an attorney or collection agency to secure payment.

In addition to weekly appointments, you will be charged for other professional services that you may require such as report writing, telephone conversations that last longer than 15 minutes, attendance at meetings or consultations which you have requested, or the time required to perform any other service which you may request of me. If you anticipate becoming involved in a court case, I recommend that we discuss this fully before you waive your right to

confidentiality. If your case requires my participation, you will be expected to pay for the professional time required even if another party compels me to testify. Please see the **treatment agreement.**

Professional records
I am required to keep appropriate records of the psychotherapy services that I provide. I use a HIPPA compliant electronic record system. I document your reasons for seeking therapy, the goals and progress we set for treatment, your diagnosis, topics we discussed, your medical, social, and treatment history, records I receive from other providers, and copies of records I send to others. Except in unusual circumstances that involve danger to yourself, you have the right to a copy of your file. Because these are professional records, they may be misinterpreted and / or upsetting to untrained readers. For this reason, I recommend that you initially review them with me, or have them forwarded to another mental health professional to discuss the contents. If I refuse your request for access to your records, you have a right to have my decision reviewed by another mental health professional, which I will discuss with you upon your request. You also have the right to request that a copy of your file be made available to any other health care provider at your written request.

Telephone accessibility
If you need to contact me between sessions, please leave a message on my voicemail. I am often not immediately available; however, I will attempt to return your call within 48 hours. Please note that Face- to face sessions (including telehealth sessions) are highly preferable to phone sessions. However, if you are out of town, sick or need additional support, phone sessions are available. If a true emergency arises, please call 911 or any local emergency room.

Social medical and telecommunication
Due to the importance of your confidentiality and the importance of minimizing dual relationships, I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc.). I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet, and we can talk more about it.

Electronic communication
I cannot ensure the confidentiality of any form of communication through electronic media, including text messages. If you prefer to communicate via email or text messaging for issues regarding scheduling or cancellations, I will do so. While I may try to return messages in a timely manner, I cannot guarantee immediate response and request that you do not use these methods of communication to discuss therapeutic content and/or request assistance for emergencies. **Services by electronic means, including but not limited to telephone communication, the Internet, facsimile machines, and e-mail.** If you and your therapist chose to use information technology for some or all of your treatment, you need to understand that:

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(1) You retain the option to withhold or withdraw consent at any time without affecting the right to future care or treatment or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled. (2) All existing confidentiality protections are equally applicable. (3) Your access to all medical information transmitted during a telemedicine consultation is guaranteed, and copies of this information are available for a reasonable fee. (4) Dissemination of any of your identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without your consent. (5) There are potential risks, consequences, and benefits of telemedicine. Potential benefits include, but are not limited to improved communication capabilities, providing convenient access to up-to-date information, consultations, support, reduced costs, improved quality, change in the conditions of practice, improved access to therapy, better continuity of care, and reduction of lost work time and travel costs. Effective therapy is often facilitated when the therapist gathers within a session or a series of sessions, a multitude of observations, information, and experiences about the client. Therapists may make clinical assessments, diagnosis, and interventions based not only on direct verbal or auditory communications, written reports, and third person consultations, but also from direct visual and olfactory observations, information, and experiences. When using information technology in therapy services, potential risks include, but are not limited to the therapist's inability to make visual and olfactory observations of clinically or therapeutically potentially relevant issues. Potential consequences thus include the therapist not being aware of what he or she would consider important information, that you may not recognize as significant to present verbally the therapist.

Minors

If you are a minor, your parents may be legally entitled to some information about your therapy. I will discuss with you and your parents what information is appropriate for them to receive and which issues are more appropriately kept confidential.

Termination

Ending relationships can be difficult. Therefore, it is important to have a termination process in order to achieve some closure. The appropriate length of the termination depends on the length and intensity of the treatment. I may terminate treatment after appropriate discussion with you and a termination process if I determine that the psychotherapy is not being effectively used or if you are in default on payment. I will not terminate the therapeutic relationship without first discussing and exploring the reasons and purpose of terminating. If therapy is terminated for any reason or you request another therapist, I will provide you with a list of qualified psychotherapists to treat you. You may also choose someone on your own or from another referral source. Should you fail to schedule an appointment for three consecutive weeks, unless other arrangements have been made in advance, for legal and ethical reasons, I must consider the professional relationship discontinued.

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Confidentiality

Mental health services are confidential EXCEPT when:

- You are in danger of harming yourself or someone else
- There is suspicion that a child has been harmed or neglected
- There is suspicion that a person age 60 or older has been harmed or neglected
- There is suspicion that a disabled person age 18-59 has been harmed or neglected
- A court issues an order to obtain mental health records

My policies about confidentiality, as well as other information about your privacy rights, are fully described in a separate document entitled Notice of Privacy Practices.

Psychotherapist-Client therapy agreement

I give Eunice Aviles, PsyD, LMHC, LPC authorization to provide mental health care to:

___ Me: Please print your name: _____ DOB: _____

___ My child or adult or minor for whom I am the guardian:
Please print name: _____ DOB: _____

Client/ guardian's initials

___I have read this complete form and understand that this consent will remain in effect as long as I or my child or adult or minor for whom I am the guardian is a client of Eunice Aviles, PsyD, LMHC, LPC. I may revoke this authorization at any given time in writing.

___This form has been read to me and I understand its contents.

_____ _____
Person served signature (Adult or Minor 14 years or older) Date

_____
Printed Legal Name

_____ _____
Parent/Guarding signature Date

_____
Printed Legal Name

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TREATMENT AGREEMENT (Initial what applies)

Client/ guardian's initials

___ I agree to attend each scheduled appointment and to notify more than 24 hours in advance if I must cancel.

___ I understand that Eunice Aviles, PsyD, LMHC, LPC's fees are $195 per initial interview and $165 per follow up session. A $25 returned-check fee will be assessed.

___ I agree to pay the full session fee if I do not cancel the appointment with at least 24 hours' notice **or** if I fail to show up to the appointment. Payment **must be** made prior to scheduling a new appointment.

___ I understand and agree that if I miss three (3) appointments and have not called 24 hours ahead to say that I must cancel those appointments, I will be discharged from treatment.

___ Should Eunice Aviles, PsyD, LMHC, LPC participate with my insurance plan, all deductibles, co-payments and co-insurance payments are **due at the time services are rendered**. **Should Eunice Aviles, PsyD, LMHC, LPC not participate with my insurance Plan, payment is due in full at the time services are rendered.**

___ The regular hourly session fee ($165.00) will be charged for every hour dedicated to case consultation, case discussion, court attendance, legal briefings, or other services performed (i.e. letters).

___Telephone conversations between us, for any reason, in excess of (15) minutes per day will be billed proportional to your hourly fee.

___ I agree to pay the fee of $250.00 for medically necessary procedures letter for gender confirmation prior to the letter being sent to the rendering provider.

___ I have the right to inspect and receive a copy of certain areas of my behavioral health care information. I understand there is a $15.00 charge for the first 15 pages and .25¢ for each additional page. An additional fee will be charged to cover the cost of postage and mailing.

___ I have the right to request a summary of treatment. I understand there is a charge of $165.00 per summary.

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TREATMENT AGREEMENT (Continuation)

Client/
guardian's initials

___ I understand it is my responsibility to obtain an authorization and/or referral for treatment from my insurance and/or primary care physician (as required by my health insurance) and have these referrals/authorizations renewed as needed and if I do not obtain and/or renew these I am responsible for payment.

___ I authorize the release of medical information necessary to process health insurance claims.

___ I authorize and request my insurance company to pay the amount due on my pending claim for health care to Eunice Aviles, PsyD, LMHC, LPC. I agree that I will make payment within 90 days of the date of service if my insurance company has not paid, and that is my responsibility to contact my insurance company for reimbursement. Should my insurance company deny the claim for any reason, I am fully responsible for payment. I agree that should my account ever get turned over to an attorney or collection agency I am responsible for reasonable attorneys and collection costs as well as interest at eighteen (18%) percent per annum associated with my account.

___ I understand that if the need arises to share information with other professional(s) or to request information from another professional that is part of my treatment team, I will be asked to sign a release of information form.

___ I have received and been given the opportunity to read a copy of Eunice Aviles, PsyD, LMHC. LPC's Notice of Privacy Practices. If I have questions about this matter I will contact Eunice Aviles, PsyD, LMHC, LPC.

___ I have received and been given the opportunity to read a list of my Rights and Responsibilities as a person served by Eunice Aviles, PsyD, LMHC, LPC. If I have questions about this matter, I will contact Eunice Aviles, PsyD, LMHC, LPC.

___I permit a copy of this authorization to be used in place of the original.

___I may revoke any part of this authorization at any time in writing. I understand that a revocation is not valid to the extent that Eunice Aviles, PsyD, LMHC, LPC has acted in Reliance on such authorization.

___ Other: _____

_____ _____
Person served legal name/Guarding signature Date

_____ _____
Eunice Aviles, PsyD, LMHC, LPC Date

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Emergency contact information

Person served legal name: _____ DOB: _____

Who can I contact in case of an emergency?

Name:	Name:
Relationship:	Relationship:
Address:	Address:
Phone number:	Phone Number:

I agree for Eunice Aviles, PsyD, LMHC, LPC to call the contact person/s in case of any emergency.

_____ _____
Person Served/Legal guardian signature Date

Allergies

Are you allergic to any medication, food, latex, and/or other environmental factors?

Please specify: _____

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NOTICE OF RECEIPT OF PRIVACY PRACTICES

- I_____(parent/guardian of:_____) acknowledge that I have been informed about Eunice Aviles, PsyD, LMHC, LPC Notice of Privacy Practices.
- I understand that the Notice of Privacy Practices discusses how my personal health care information may be used and/or disclosed and explains my rights with respect to health care information; including how and where I may file a privacy-related complaint.
- I may review a copy of this Notice in the office.
- I may obtain another copy of this Notice by requesting one from Eunice Aviles, PsyD, LMHC, LPC.
- I understand that the terms of this Notice may be changed in the future, I agree that this office has the right to make future changes, and that any changes will be posted in the agency. I may also request a copy of the new Notice by contacting Eunice Aviles, PsyD, LMHC, LPC.

_____ _____
Person served legal name/Guarding signature Date

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Health Insurance Portability Accountability Act (HIPAA)
Client Rights & Therapist Duties

This document contains important information about federal law, the Health Insurance Portability and Accountability Act (HIPAA), that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations.

HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice explains HIPAA and its application to your PHI in greater detail.

The law requires that I obtain your signature acknowledging that I have provided you with this. If you have any questions, it is your right and obligation to ask so I can have a further discussion prior to signing this document. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding, unless I have taken action in reliance on it.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communication between a patient and a therapist. In most situations, I can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. There are some situations where I am permitted or required to disclose information without either your consent or authorization. If such a situation arises, I will limit my disclosure to what is necessary. Reasons I may have to release your information without authorization:

1. If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the psychotherapist-patient privilege law. I cannot provide any information without your (or your legal representative's) written authorization, or a court order, or if I receive a subpoena of which you have been properly notified and you have failed to inform me that you oppose the subpoena. If you are involved in or contemplating litigation, you should consult with an attorney to determine whether a court would be likely to order me to disclose information.
2. If a government agency is requesting the information for health oversight activities, within its appropriate legal authority, I may be required to provide it for them.
3. If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
4. If a patient files a worker's compensation claim, and I am providing necessary treatment related to that claim, I must, upon appropriate request, submit treatment reports to the appropriate parties, including the patient's employer, the insurance carrier or an authorized qualified rehabilitation provider.

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5. I may disclose the minimum necessary health information to my business associates that perform functions on my behalf or provide me with services if the information is necessary for such functions or services. My business associates sign agreements to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm, and I may have to reveal some information about a patient's treatment:

1. If I know, or have reason to suspect, that a child under 18 has been abused, abandoned, or neglected by a parent, legal custodian, caregiver, or any other person responsible for the child's welfare, the law requires that I file a report with the Massachusetts, New Jersey or Puerto Rico Abuse Hotline (Depending on the state where you reside). Once such a report is filed, I may be required to provide additional information.
2. If I know or have reasonable cause to suspect, that a vulnerable adult has been abused, neglected, or exploited, the law requires that I file a report with the Massachusetts, New Jersey or Puerto Rico Abuse Hotline (Depending on the state where you reside). Once such a report is filed, I may be required to provide additional information.
3. If I believe that there is a clear and immediate probability of physical harm to the patient, to other individuals, or to society, I may be required to disclose information to take protective action, including communicating the information to the potential victim, and/or appropriate family member, and/or the police or to seek hospitalization of the patient.

CLIENT RIGHTS AND THERAPIST DUTIES

Use and Disclosure of Protected Health Information:

- ***For Treatment –*** I use and disclose your health information internally in the course of your treatment. If I wish to provide information outside of my practice for your treatment by another health care provider, I will have you sign an authorization for release of information. Furthermore, an authorization is required for most uses and disclosures of psychotherapy notes.
- ***For Payment*** – I may use and disclose your health information to obtain payment for services provided to you as delineated in the Psychotherapist-Client therapy agreement.
- ***For Operations*** – I may use and disclose your health information as part of internal operations. For example, this could mean a review of records to ensure quality. I may also use your information to tell you about services, educational activities, and programs that I feel might be of interest to you.

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Patient's Rights:

- ***Right to Treatment*** – You have the right to ethical treatment without discrimination regarding race, ethnicity, gender identity, sexual orientation, religion, disability status, age, or any other protected category.
- ***Right to Confidentiality*** – You have the right to have your health care information protected. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. I will agree to such unless a law requires us to share that information.
- ***Right to Request Restrictions*** – You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.
- ***Right to Receive Confidential Communications by Alternative Means and at Alternative Locations*** – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations.
- ***Right to Inspect and Copy*** – You have the right to inspect or obtain a copy (or both) of PHI. Records must be requested in writing and release of information must be completed. Furthermore, there is a copying fee charge of $15.00 for the first 15 pages and .25¢ for each additional page. An additional fee will be charged to cover the cost of postage and mailing. Please make your request well in advanced and allow 2 weeks to receive the copies. If I refuse your request for access to your records, you have a right of review, which I will discuss with you upon request.
- ***Right to Amend*** – If you believe the information in your records is incorrect and/or missing important information, you can ask us to make certain changes, also known as amending, to your health information. You have to make this request in writing. You must tell us the reasons you want to make these changes, and I will decide if it is and if I refuse to do so, I will tell you why within 60 days.
- ***Right to a Copy of This Notice*** – If you received the paperwork electronically, you have a copy in your email and/or client secured portal. If you completed this paperwork in the office at your first session, a copy will be provided to you per your request or at any time.
- ***Right to an Accounting*** – You generally have the right to receive an accounting of disclosures of PHI regarding you. On your request, I will discuss with you the details of the accounting process.
- ***Right to Choose Someone to Act for You*** – If someone is your legal guardian, that person can exercise your rights and make choices about your health information; I will make sure the person has this authority and can act for you before I take any action.
- ***Right to Choose*** – You have the right to decide not to receive services with me. If you wish, I will provide you with names of other qualified professionals.
- ***Right to Terminate*** – You have the right to terminate therapeutic services with me at any time without any legal or financial obligations other than those already accrued. I ask that you discuss your decision with me in session before terminating or at least contact me by phone letting me know you are terminating services.

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- ***Right to Release Information with Written Consent*** – With your written consent, any part of your record can be released to any person or agency you designate. Together, we will discuss whether or not I think releasing the information in question to that person or agency might be harmful to you.

Therapist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI. I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect. If I revise my policies and procedures, I will provide you with a revised notice in office during our session.

COMPLAINTS

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact me, the State of Massachusetts, New Jersey or Puerto Rico Department of Health, or the Secretary of the U.S. Department of Health and Human Services (depending on the state where you reside).

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

_____ _____
Client/Legal Guardian Signature Date

_____
Printed Name

_____ _____
Client/Legal Guardian Signature Date

_____
Printed Name

_____ _____
Eunice Aviles, PsyD, LMHC, LPC Dat