400 Massasoit Avenue, Suite 305, East Providence RI 02914
1130 Ten Rod Road, Suite E305, North Kingstown RI 02852
Phone: (401) 294-0451 • Fax: (401) 294-0461
Receptionist@RICBT.com • www.RICBT.com

Packet for Psychologists and Psychotherapists at RICBT
For Patients 18 Years and Over

We look forward to working with you in the practice. Please read and complete each of the steps listed below as thoroughly as possible. This will take some time - between 30 and 60 minutes. However, it is important to making your work at RICBT as effective as possible. By giving much of this information before your evaluation appointment, it will make it easier to cover more ground in that first session. We don't, though, want any of this to be a barrier to care. If you have any trouble or if a section is too sensitive, just leave it blank, bring it with you, and your clinician will help you or discuss things in person. If your visit is for couple or family therapy, the person you wish to designate as the patient should complete the packet.

1. Read and sign the *Services Agreement* form.
2. Complete and sign the *Coordination of Care* forms.
3. Complete and sign the *Payment Form*.
4. Complete the Initial Evaluation Questionnaire (about your concerns and goals).

Today's Date:

Patient Name:

Age:

Date of Birth:

Address:

Marital Status:

Mobile Phone:

Home Phone:

Email:

Check to receive important practice updates and our newsletter by email: ☐

Emergency contact person. Please indicate the name of an emergency contact person for you, their relationship to you, their address, phone, and email.

Please download Adobe Reader to complete on the computer in order to save and print correctly.

RICBT Psychotherapist-Patient Services Agreement

For Patients 18 Years and Over

This Agreement contains important information about our professional services and business policies. Please ask your clinician if you have any questions.

Your first meeting is an evaluation – not an agreement to provide treatment
If your clinician determines that they are not the right match for you, they will provide you with recommendations for other providers or treatment settings that will better suit your needs.

Psychotherapy services have risks and benefits
Psychotherapy offers risks and benefits. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness and anxiety. On the other hand, therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. There are no guarantees of what you will experience. The more effort you put into the process, the more you will get out of it.

We ask you to respect that you are reserving a highly-trained professional's limited time
There is typically a $75 minimum charge for all missed appointments and cancellations made with less than 24 hours notice, regardless of your reason for the cancellation. As a courtesy, we will waive this fee once every 6 months. Insurance companies do not provide reimbursement for cancelled sessions.

Phone coaching and consultation is extra
There may be times when you need phone support outside of sessions. Some of the clinicians here do occasional phone coaching or sessions as part of their practice. These consultation sessions are not covered by insurance (because of insurance company policies, not ours); they are self-pay.

You can leave your therapist a message with the receptionist or through voicemail
Due to the nature of the work, therapists are often not immediately available by telephone. You can leave your therapist a message with the receptionist or through voicemail. They will generally return your call during the week and within a day. If you do not hear back, please call the main number and speak with the receptionist and they will make sure the clinician gets the message.

You can call 911 or go to your nearest hospital emergency room for urgent matters
Please call 911 or go to your nearest hospital emergency room if you have an urgent situation. You may also call our main number during the day to ask for guidance (401.294.0451). After hours, you may also call the director of the practice, Dr. Johnson, at 401.829.1023, leave a message describing the issue, and he will return the call and help advise you if possible. Please understand, though, that you shouldn't delay contacting 911 or going to the hospital if you have an emergency.

What you share in treatment is generally confidential and well-protected
The law protects the privacy of all communications between a patient and a psychotherapist. There are just a few exceptions and qualifications: 1. If you are being treated by multiple providers within RICBT, we have the right to discuss your case without your written consent. We will always use our discretion though, and respect your preferences. 2. Administrative staff at RICBT need access to your information to deal with scheduling, billing, and related issues. These staff members are trained to protect your privacy and confidentiality. 3. If you are involved in a court-proceeding, your records are protected unless you have received a subpoena and have not notified us that you are opposing it. In exceptional circumstances, a judge could issue a court order compelling us to release your records. 4. If we believe you are a danger to yourself or someone else, we may contact family members or authorities who can help keep everyone safe. This may include warning potential victims, contacting the police, or seeking hospitalization for you. 5. If a patient or family member files a complaint or lawsuit against a therapist or the practice, we may disclose relevant information in order to defend ourselves. 6. If you file a worker's compensation or disability claim, related information may be shared with the Worker's Compensation Commission or the disability insurance company. 7. If your clinician suspects that a child has been abused or neglected, the law requires that they file a report with the Department of Children, Youth, and Families, and provide additional information if requested.

We have extensive privacy policies for your treatment records
We are required to keep information about you and your treatment in your Clinical Record. A document called the Rhode Island Notice Form is available at RICBT.com. It describes how we try to protect the privacy of your Protected Health Information (PHI) as mandated by the Health Insurance Portability and Accountability Act (HIPAA), as well as your rights. We continually assess our practices to ensure record security. If we suspect a serious breach of your information has occurred, we will provide any required notice to you and Health and Human Services. You may receive a copy of your record or have it forwarded to another healthcare professional.

You may be treated by a Graduate Student or Postdoctoral Psychotherapist working under supervision
Some of our clinicians are unlicensed graduate students or postdoctoral fellows completing professional training and working under supervision by a licensed psychologist at RICBT. They charge lower fees and do not bill insurance. The Intake Coordinators will make it clear whether you are scheduled with one of these providers; your clinician's status is also listed on our website. You are welcome to ask your clinician who supervises them. You are also welcome to speak at any point with the Director of RICBT, Dr. Ben Johnson, if you have any questions or feedback (BenJohnson@RICBT.com).

We use technology thoughtfully and carefully, and have a social media policy
We prefer to use email and text messages to communicate about some administrative issues, though you don't have to use either. If you do email or text with us, we cannot guarantee confidentiality, though we have rarely had problems with it. Email and text messages should not be used to exchange urgent or highly confidential information. In terms of social media, we invite you to like and follow our RICBT Facebook, Twitter, and Instagram pages. Clinicians don't accept links from patients on their personal pages.

We require payment at the time of service and encourage putting a credit card on file
Most people put a credit card on file that will be automatically charged after each session. You may also pay with cash or check. If a parent or someone else is paying for your treatment, all communication will still go through you, and it is still your responsibility to ensure payment is made at each session. If you do not pay your bill, you will not be able to continue to receive treatment here. Overdue balances are subject to a billing fee of $10 per month.

Please try to understand your health insurance and what we accept
You can choose whether or not to use your insurance for your work here, regardless of whether you have it. Please make sure you fully understand whether we are submitting claims for you, whether we are in-network or out-of-network with your carrier, what your net cost will be for our services, and whether you need insurance authorization. If your insurance changes, please let us know immediately, and understand that you need to be able to pay for services in order to continue in treatment with us. We have a number of lower fee treatment options if needed. You are ultimately responsible for services your insurance doesn't cover. If we are submitting insurance claims for you, we will provide the carrier the minimum information they require to process claims.

Your signature means you accept the terms of this Agreement
Again, please note our missed appointment policy of $75 per session, regardless of the reason, to cover the reservation of a professional's time.

Today's Date:

Patient Name:

Signature:

400 Massasoit Avenue, Suite 305, East Providence RI 02914
1130 Ten Rod Road, Suite E305, North Kingstown RI 02852
Phone: (401) 294-0451 • Fax: (401) 294-0461
Receptionist@RICBT.com • www.RICBT.com

Communication Between your Primary Care Physician (PCP) and your RICBT Psychologist(s)/Psychotherapist(s)

Please note that we are required to have this form on file for you. We encourage you to allow us to coordinate your care with your PCP. Modern science and the current healthcare system emphasize integrating the treatment of mind and body.

Please select one of the following:

- ◯ I do not currently have a PCP.
- ◯ I do NOT wish any of my health information to be exchanged with my PCP.
- ◯ I authorize the use, disclosure, and exchange of my health information as described in this authorization. I also authorize sending a Coordination of Care Letter to this provider, describing that I have been evaluated at RICBT and what preliminary diagnoses I have been given (may include information about substance abuse and HIV status).

  PCP name, address, phone, and fax (we appreciate as much info as you can provide to correctly identify and locate your provider):

This authorization will have a duration of consent for the duration of active treatment. This authorization gives permission to exchange information by phone, fax, photocopies, or secured email. Information to be released includes any or all progress notes, evaluations, treatment plans, and chart notes from RICBT or other providers that have become part of the treatment record. Information will pertain to any and all Dates of Service. Indicate information you do not want exchanged (if any) on the bottom of this form. The purpose of the requested information to be exchanged is for enhancing effective and coordinated care. I understand that the information in the health record may relate to alcohol or drug abuse and my description of my HIV (human immunodeficiency) status. Unless I have indicated otherwise on this sheet, I specifically authorize the release of this information. I understand that I have the right to revoke this authorization at any time. To revoke, I must contact RICBT and put my revocation in writing. I understand that it will not apply to information that has already been released. I also understand that if I authorize RICBT to disclose information, the recipient of the information might disclose it to others, and that any information disclosed may no longer be protected by the federal rule on the privacy of medical records.

Today's Date:

Patient Name:

Signature of Patient or Authorized Representative:

400 Massasoit Avenue, Suite 305, East Providence RI 02914
1130 Ten Rod Road, Suite E305, North Kingstown RI 02852
Phone: (401) 294-0451 • Fax: (401) 294-0461
Receptionist@RICBT.com • www.RICBT.com

Communication Between your Psychiatric Prescriber Outside of RICBT and your RICBT Psychologist(s)/Psychotherapist(s)

If you are seeing a psychiatrist at RICBT, we will coordinate care internally and this authorization is not required. If you are seeing a psychiatrist or nurse practitioner outside of RICBT, we strongly encourage you to allow us to coordinate care.

Please select one of the following:

- ◯ I am not currently on psychiatric medication.
- ◯ My PCP prescribes my psychiatric medication.
- ◯ I authorize the use, disclosure, and exchange of my health information as described in this authorization with my psychiatric medication prescriber. I also authorize sending a Coordination of Care Letter to this provider, describing that I have been evaluated at RICBT and what preliminary diagnoses I have been given (may include information about substance abuse and HIV status).

  Psychiatric medication prescriber's **name, address, phone, and fax** (we appreciate as much info as you can provide to correctly identify and locate your provider):

This authorization will have a duration of consent for the duration of active treatment. This authorization gives permission to exchange information by phone, fax, photocopies, or secured email. Information to be released includes any or all progress notes, evaluations, treatment plans, and chart notes from RICBT or other providers that have become part of the treatment record. Information will pertain to any and all Dates of Service. Indicate information you do not want exchanged (if any) on the bottom of this form. The purpose of the requested information to be exchanged is for enhancing effective and coordinated care. I understand that the information in the health record may relate to alcohol or drug abuse and my description of my HIV (human immunodeficiency) status. Unless I have indicated otherwise on this sheet, I specifically authorize the release of this information. I understand that I have the right to revoke this authorization at any time. To revoke, I must contact RICBT and put my revocation in writing. I understand that it will not apply to information that has already been released. I also understand that if I authorize RICBT to disclose information, the recipient of the information might disclose it to others, and that any information disclosed may no longer be protected by the federal rule on the privacy of medical records.

Today's Date:

Patient Name:

Signature of Patient or Authorized Representative:

400 Massasoit Avenue, Suite 305, East Providence RI 02914
1130 Ten Rod Road, Suite E305, North Kingstown RI 02852
Phone: (401) 294-0451 • Fax: (401) 294-0461
Receptionist@RICBT.com • www.RICBT.com

Communication Between your Other Healthcare Providers Outside of RICBT and your RICBT Psychologist(s)/Psychotherapist(s)

(e.g., OB/GYN, neuropsychologist, past psychotherapists)

We would be happy to coordinate your care with any other health care providers that are or have been involved in your treatment.

Please select one of the following:

○ There are no other providers with whom I would like you to coordinate my care.

○ I authorize the use, disclosure, and exchange of my health information as described in this authorization with my additional providers.

Name, address, phone, and fax of each additional provider (we appreciate as much info as you can provide to correctly identify and locate your provider):

This authorization will have a duration of consent for the duration of active treatment. This authorization gives permission to exchange information by phone, fax, photocopies, or secured email. Information to be released includes any or all progress notes, evaluations, treatment plans, and chart notes from RICBT or other providers that have become part of the treatment record. Information will pertain to any and all Dates of Service. Indicate information you do not want exchanged (if any) on the bottom of this form. The purpose of the requested information to be exchanged is for enhancing effective and coordinated care. I understand that the information in the health record may relate to alcohol or drug abuse and my description of my HIV (human immunodeficiency) status. Unless I have indicated otherwise on this sheet, I specifically authorize the release of this information. I understand that I have the right to revoke this authorization at any time. To revoke, I must contact RICBT and put my revocation in writing. I understand that it will not apply to information that has already been released. I also understand that if I authorize RICBT to disclose information, the recipient of the information might disclose it to others, and that any information disclosed may no longer be protected by the federal rule on the privacy of medical records.

Today's Date:

Patient Name:

Signature of Patient or Authorized Representative:

RICBT

400 Massasoit Avenue, Suite 305, East Providence RI 02914
1130 Ten Rod Road, Suite E305, North Kingstown RI 02852
Phone: (401) 294-0451 • Fax: (401) 294-0461
Receptionist@RICBT.com • www.RICBT.com

Communication Between your Family Members and your RICBT Psychologist(s)/Psychotherapist(s)

We encourage you to involve your family members in your treatment. It can often be useful to bring a family member in to share their perspective on issues. Please discuss the options with your clinician.

○ I do NOT authorize any communication with any of my family members or friends.

○ I authorize RICBT to communicate about:

☐ routine scheduling or billing issues

☐ any aspect of my treatment

with the family members indicated. Please include **names, relationship to you, phone, and email**:

This authorization will have a duration of consent for the duration of active treatment. This authorization gives permission to exchange information by phone, fax, photocopies, or secured email. Information to be released includes any or all progress notes, evaluations, treatment plans, and chart notes from RICBT or other providers that have become part of the treatment record. Information will pertain to any and all Dates of Service. Indicate information you do not want exchanged (if any) on the bottom of this form. The purpose of the requested information to be exchanged is for enhancing effective and coordinated care. I understand that the information in the health record may relate to alcohol or drug abuse and my description of my HIV (human immunodeficiency) status. Unless I have indicated otherwise on this sheet, I specifically authorize the release of this information. I understand that I have the right to revoke this authorization at any time. To revoke, I must contact RICBT and put my revocation in writing. I understand that it will not apply to information that has already been released. I also understand that if I authorize RICBT to disclose information, the recipient of the information might disclose it to others, and that any information disclosed may no longer be protected by the federal rule on the privacy of medical records.

Today's Date:

Patient Name:

Signature of Patient or Authorized Representative:

400 Massasoit Avenue, Suite 305, East Providence RI 02914
1130 Ten Rod Road, Suite E305, North Kingstown RI 02852
Phone: (401) 294-0451 • Fax: (401) 294-0461
Receptionist@RICBT.com • www.RICBT.com

RICBT Payment and/or Credit Card Authorization Form

Once you put a credit card on file with us, you don't need to present the card at each session. You may also pay by cash or check at the time of service or pay in advance for a number of sessions.

Payment preference:

- ◯ I would like to pay by cash or check (payable to RICBT) before or at the time of service.
- ◯ I would like to put a credit card on file that will be charged after each session.

  Card type:
  - ◯ MasterCard
  - ◯ Visa

  Check if this is a debit card: ☐ Check if this is an FSA/HSA card: ☐

  Name of patient:

  Name on credit card:

  Billing address of cardholder (if different from patient address):

  Credit Card Number:

  Expiration Date (MM/YY):

  ☐ I would like an email receipt sent to:

Today's Date:

Signature:

RICBT Initial Evaluation Questionnaire (for Patients 18 years and over)

This questionnaire asks you to share details about your problems and life history. This information is critical to conducting a thorough evaluation. By completing this form before the initial meeting, much time will be saved and more ground will be covered in the first few sessions. Broadly, our goal is to get to know you. Please write in as much or little detail as you would like.

Patient Name: **Today's Date:**

Date of Birth:

Current problems and concerns. Please describe the key problems for which you are currently seeking treatment and when they began. Feel free to note situations that are difficult for you, as well as problematic moods, thoughts, and behaviors.

Your current family and living environment. Please note immediate family members (parents, spouse, children, or close relatives). What are their names and ages? Where do they live? Please describe the personalities and styles of the people you live with and your relationship with them. Note the level of conflict, tension, or stress in your living environment. Which patterns at home may contribute to your difficulties?

Your developmental history. Please tell us about your family growing up and your childhood. Where were you born? Please describe the personalities of family members, their emotional style, and how people related to each other. Please describe with what emotional or mental health problems people in your family of origin and close relatives struggle.

Major stressors or traumatic events. Please note any highly upsetting and traumatic events you have endured. Were you sexually, physically, or emotionally abused at any point in your life?

Your current work, school, and social environment. What is your current occupational or educational status? Please describe what work or school is like for you and what things about it may contribute to your difficulties. How would you describe your current friend and social support network?

Current physical health. Please describe your current physical health and any current problems with it.

Past physical health problems. Please describe any significant past medical problems and treatments (e.g., surgeries).

Current medications. Please list all psychiatric and non-psychiatric medications you are currently taking. Please include the dosage, prescriber, and reason for taking. Indicate if you are not on any medications.

Past psychiatric medications. Have you been on any psychiatric medications in the past?

Substance use and addictive behaviors.

Check here if you currently smoke cigarettes or use nicotine products (any amount): ☐

Check here if would you like a referral to a smoking cessation program: ☐

Please note any other issues you have or have had with substances such as alcohol, marijuana, cocaine, prescription medications, gambling, pornography, or other addictive patterns.

Mental health treatment history. Please describe your past experiences in inpatient and outpatient treatment. Please note psychologists, therapists, or counselors you have seen, approximate dates of treatment and number of sessions, what led you to seek treatment, and what it was like for you. For inpatient or day hospital programs, please note which facility or program you were in, the dates of treatment, and what led you to be in the hospital.

History of self-injury and suicidal feelings. Sometimes people hurt or injure themselves when they are upset or stressed. Do you do anything like that? Have you had times where you were thinking a lot about suicide? If so, please briefly describe when and whether you made a suicide attempt or a suicidal gesture. Have you ever been so upset that you thought about hurting others? If you feel unsafe before your first appointment here, please go to your nearest hospital emergency room, call your primary care doctor, and/or let us know if you need guidance.

Other symptoms. Please note any difficulties with your concentration, memory, appetite, sleep, or sexual functioning. Note any other symptoms you haven't yet noted in this questionnaire.

Other things your clinician should know? Please describe anything else that is important to know in understanding your life and your difficulties.

Signature: