Many Moons Psychotherapy Services, Inc.
an arts-based approach to emotional health
4 Cottage Street
Freeport, Maine 04032
office: 207-504-2664
www.manymoonstherapy.org

Demographic Information

Intake Date:

Client Name:

Date of Birth:

Social Security Number:

Parent/Guardian Name:		Parent/Guardian Name:	
Home address:	_____	Home address:	_____
	_____		_____
Date of birth:	_____	Date of birth:	_____
Home phone:	_____	Home phone:	_____
Cell phone:	_____	Cell phone:	_____
Work phone:	_____	Work phone:	_____
Name of employer:	_____	Name of employer:	_____

Secondary contact in case of emergency:

Primary Care Physician:

Medications:

Current School/ Grade:

Insurance Information:
- Subscriber's name and date of birth:
- Subscriber's home address (if different from above):
- Subscriber's employer (if different from above):
- Carrier, ID# and Group#:

I understand that I am financially responsible for services not covered by my insurance, including a $70.00 fee for any missed appointments if I have not notified my provider within 24 hours in advance. I understand that I will be charged a late fee for unpaid co-pays/bills after 30 days. I understand that I will be billed for any consultation services between my provider and anyone I signed a release for her to speak with. I hereby authorize my provider to disclose information about my diagnosis and treatment to my insurance company. I understand and authorize charges due to consultation with other providers, school personnel, and legal parties. These charges are not covered by my insurance benefits.

Client Signature:_____ Date:_____

Parent/Guardian Signature:_____ Date:_____

Parent/Guardian Signature:_____ Date:_____

Clinician Signature:_____ Date:_____

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Disclosure Statement & Informed Consent

Informed Consent:
I, _____, parent/ guardian of _____, agree and consent to participate in mental health services offered and provided by Many Moons Psychotherapy Services Inc. I understand that I am consenting only to those services that my clinician is qualified to provide within the scope of her professional license and training. I have been informed of the nature of the proposed treatment and the risks and benefits of such treatment. I understand that I can seek a second opinion, terminate treatment at any time and can inquire about my provider's methods, training and licensing.

Privacy Practices:
Congress passed a law known as HIPAA (Health Insurance Portability and Accountability Act), which is designed to protect your privacy. The law requires you to sign a form that acknowledges your access and receipt of our Notice of Privacy Practices. The Notice of Privacy Practices describes in detail which health care information, such as diagnosis, treatment goals and medications, we may release or discuss with other providers and insurance companies. I hereby acknowledge that I have been offered a copy of Many Moons Notice of Privacy Practices and agree to its terms. If I have any questions, I am free to ask and will be furnished with the answers. I understand that my personal information will be respected and managed in the most confidential and sensitive manner possible and can further discuss the limitations of confidentiality with my provider.

Disclosure Statement:
All clinicians at Many Moons are fully licensed by the State of Maine and abide by its Professional Code of Ethics. To maintain his/her license, my provider is required to participate in annual continuing education and supervision. For any questions regarding the licensing rules and regulations, or to submit a grievance, I understand that I can contact: Office of Licensing and Registration, 35 State House Station, Augusta, ME 04333-0035, (207) 624-8660, http://www.maineprofessionalreg.org .

The full fee for psychotherapy services is displayed on the sliding fee form. I am responsible for all co-pays and co-insurances. I understand that I am responsible for paying for services not covered by insurance, such as consultation between my provider and anyone I have signed a release for her to speak with. I am responsible for paying for fees related to testimony in court, even if my attorney did not initiate the subpoena. If I have private insurance, I have the option of: 1. using my insurance benefits, 2. paying my provider in full and then submitting for reimbursement or 3. utilizing the sliding scale. I will be charged a fee of $70.00 for canceling an appointment within 24 hours or not showing up at the scheduled time. A $10.00 fee will be applied for late payments.

Due to the nature of expressive therapies, my clinician may use tools or items to enhance the therapeutic experience. These tools or materials may include musical instruments, sharp pencils, paints, scissors etc. I take full responsibility for any injuries incurred while participating in expressive therapies. I/my child will never be forced to use a tool or material and all involvement with these instruments will be done at my own risk.

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Parent/Guardian Signature:_____ Date:_____

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Confidentiality Agreement

I, _____, parent/guardian of _____ understand that under certain circumstances, the confidentiality of my identity, personal information and participation in treatment may be compromised. I understand and accept that the following are situations in which this may happen:

1. The clinicians at Many Moons are Mandated Reporters. This means that they are required to contact outside sources, such as a family member, law enforcement, The Department of Health and Human Services or a member of the community to protect the safety of their clients and their families. The clinicians are required by law to break the confidentiality when a client reports a plan to cause significant harm to themselves or others or is in danger of being harmed by someone other than themselves.

2. Many Moons contracts with a bookkeeping company and payroll company to manage financial aspects of the business. At times, contractors have access to clinical files.

3. Many Moons uses computer and technical support services in which the technician may have access to clinical files.

4. In the event that the clinician is ill and unable to contact clients directly, a contracted professional colleague may contact clients to cancel an appointment. This covering clinician may have access to clinical files.

5. In the event of carrying a significant financial balance, Many Moons maintains the right to employ a collections agency to attempt to collect funds and have access to demographic information.

I am aware and accept that the clinicians will use their utmost care to disclose as little information as possible during these events. I understand that I can inquire about how my information is being shared at any time.

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Social Media Policy & Disclosure Statement

This document outlines the **Digital and Social Media** policy outlines how you can expect Many Moons clinicians to respond to various digital (online) interactions. The two primary goals are to: 1. maintain your confidentiality and privacy and 2. have clear, consistent boundaries for our therapeutic relationship. By signing this form, you agree to be contacted via phone, text, email or social media and that this contact may disclose your affiliation with Many Moons.

Email, Texting, Messaging Communication: Email is an easy, direct and useful means to communicating. We prefer using email for scheduling and financial dialogue. Please do not email content related to your therapy sessions, as email is not completely secure or confidential. If you choose to communicate by email, be aware that all emails are retained in the logs of Internet service providers. While it is unlikely that someone will be looking at these logs, they are, in theory, available to be read by the system administrator(s) of the Internet service provider. You should also know that any emails sent and received become a part of your legal record. In addition, work emails (@manymoonstherapy.org) are forwarded to personal email addresses in order to most promptly contact you. This further complicates your privacy. Please do not email if you are not comfortable with replies from either server. As with email, texting is a fast and efficient way to connect about urgent scheduling matters (car trouble, snow, sudden illness). However, texting adds a unique challenge to established boundaries. Even though text messages can/could e received immediately, this does not ensure you'll get a prompt response. Please bring your concerns about this so it can be openly addressed. Cellphones and websites are not secure and present a host of challenges to maintaining your confidentiality.

Social Networks and Internet Presence: We do not accept friend or contact requests from current or former clients on any social networking sites. Adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. If you have questions about this, please bring them up when we meet and we can talk more about it. You are welcome to "like" the Many Moons Facebook Page. Your presence on that page may be viewable to the public and may disclose your connection. Many Moons clinicians do not search for clients on Google or Facebook or other search engines. Extremely rare exceptions *may* be made during times of crisis due to a strong safety concern. You may find Many Moons on sites that list mental health businesses. Some of these sites include forums in which users rate their providers and add reviews. If you see our listing on any of these sites, please know that it is not a request for a testimonial, rating, or endorsement from you as my client. Of course, you have a right to express yourself on any site you wish. Due to confidentiality, we will not respond to any review on any of these sites whether it is positive or negative. You should also be aware that if you are using these sites to communicate indirectly, it may not be received.

GPS Tracking: If you used location-based services on your mobile phone, or "check-in" at the office, this may compromise your privacy. If you have GPS tracking enabled on your device, it is possible that others may surmise that you are a therapy client due to regular check-ins at my office on a weekly basis. Please be aware of this risk if you are intentionally "checking in," from the office.

I understand this disclosure statement. I give my authorization to use and receive text messages, emails and possible messaging on the internet. I understand that these digital communication vehicles could compromise my confidentiality, confuse my understanding of my therapist's availability outside our sessions, and blur the therapeutic relationship boundary. I feel adequately informed about how I can protect my privacy and confidentiality.

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Consent About Clinical Artwork

Name of Client: _____

The creation of artwork at Many Mons is an integral part of the therapeutic process. Artwork created during therapy sessions can often contain personal information and clinical content. By signing this form, I understand the following components of physical artwork that is left at the office after a clinical session.

I understand that my/ my child's artwork may:
- be seen, touched, or damaged by other clients or clinicians
- be displayed in a public area within the office building
- be used to teach others about expressive therapies
- release information about myself, my family and their/my mental health needs
- be used for marketing purposes (this includes photographs of myself/my child)
- be taken apart/disassembled if left in the office after a session

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Authorization for Release of Information

This authorization is only valid for the purpose stated below. All clinicians at Many Moons Inc. must obtain written authorization before requesting or disclosing any information from or to any person or agency. Please read thoroughly before signing. This release will remain active throughout the duration of treatment, unless clearly revoked.

I, _____, Parent/ Guardian of _____ agree to:

Release information to AND obtain information from:

Name:

Address/Phone Number:

The following specific information:
☐ Participation in Treatment
☐ Assessment
☐ Treatment Plan
☐ Progress notes
☐ Discharge Report
☐ After-Care Recommendations
☐ Other: _____

For the Purpose of:
☐ Coordination for Services
☐ Referrals for Treatment
☐ Treatment Planning
☐ Other:_____

☐ I permit disclosure of any information about my substance abuse history.
☐ I permit disclosure of any information about my diagnosis/ treatment of HIV or AIDS.

I understand I have the right to review all materials prior to their release, and that the materials to be released will be reviewed with me upon my request. ***I understand that I may be billed for consultation between Many Moons and the parties noted above.*** *I have been offered a copy of this release, as well as the fee scale of rates. I understand that materials may be released in written, fax or verbal form. This release will expire on the date of termination of therapy services.*

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Parent/Guardian Signature:_____ Date:_____

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Informed Consent for In-Person & Telehealth Services DURING COVID-19 PANDEMIC

I, _____, Parent/ Guardian of _____ hereby consent to engage in both/either telehealth services and in-person services with Many Moons, Inc. and its clinicians, as part of my/my child's psychotherapy treatment. I have read and understand the information provided below. I have the right to discuss any of this information with my provider. I understand that I can withdraw my consent by providing written notification. My signature below indicates that I have read this Agreement and agree to its terms.

IN-PERSON SERVICES:

Both you and your clinician have agreed to meet in-person for some or all future sessions, during the coronavirus pandemic. If there is a resurgence of cases or if other health concerns arise, however, Many Moons may determine that services via telehealth is the safest option. You are always free to change/resume telehealth services. By physically entering the office, you are assuming the risk of exposure to the coronavirus (or other public health risks). This risk may increase if you travel by public transportation or participate in community events. Many Moons has taken many steps to reduce the risk of spreading the coronavirus within the office and has posted efforts on the website and in the office.

Risks & Responsibilities:

To obtain services in person, you agree to take certain precautions which will help keep yourself, your clinician, and other people on Many Moons property safe. These precautions may change as additional local, state or federal guidelines are published.

- You will only keep your in-person appointment if you are symptom free. If you have any symptoms of the coronavirus, you agree to cancel the appointment or proceed using telehealth. If you wish to cancel for this reason, there is no typical cancellation fee.
- To maintain social distancing, you will wait in the driveway or car and your clinician will greet you outside.
- When able/willing, you will wear and mask and wash your hands or use alcohol-based hand sanitizer when you enter and exit the building.
- If you are bringing your child, you will make sure that your child follows all of these sanitation and distancing protocols.
- If your commute or other responsibilities or activities put you in close contact with others (beyond your family), you will let your clinician know.
- If you have exposure to anyone who tests positive for the corona virus, you will resume telehealth.
- If you have tested positive for the coronavirus, Many Moons *may be* required to notify local health authorities that you have been in the office. Only minimum information necessary for their data collection will be disclosed.

TELEHEALTH SERVICES:

Both you and your clinician have agreed to meet via telehealth for some or all future sessions, during the coronavirus pandemic. You are always free to change/resume in-person services, when both you and your clinician determine that it is safe to do so. I understand that "telehealth" includes the practice of diagnosis, consultation, treatment, transfer of clinical data, and education using interactive audio, video, or data communications. Please note that reimbursement/coverage for telehealth services is also determined by the insurance companies and may be different from in-person services.

Risks & Responsibilities:

I have a right to confidentiality with Telehealth under the same laws that protect the confidentiality of my medical information for in-person psychotherapy. Any information disclosed by me during the course of my therapy, therefore, is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality. And I understand that there are risks unique and specific to Telehealth, including but not limited to:

- our therapy sessions could be: a.) disrupted, distorted, disconnected by technical failures, b.) interrupted by a family member or person present in my home, c.) inadvertently accessed by unauthorized persons
- my therapist may hear or view things within my home that I did not intentionally disclose
- any personally identifiable images or information from the teletherapy interaction becomes part of my clinical record, despite my written consent or intention to disclose such information.
- some technologies and their use do not comply with current HIPAA requirements. However, given the current COVID-19 pandemic, covered healthcare providers can use any non-public facing remote, audio or video communication product available to provide telehealth services and to more generally communicate about non-clinical matters. It applies to all uses of telehealth provided for any reason, regardless of whether the service is directly related to the diagnosis or treatment related to COVID-19 health conditions.

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Card "On- File" Payment Policy

Client:

Parent/Guardian:

1st Card Number: _____ Is this an HSA card? _____

Expiration Date: ____ /____

CVV Code: __ __ __

Billing zip code: __ __ __ __ __

2nd Card Number: _____ date provided: _____

Parent/Guardian:

Expiration Date: ____ /____

CVV Code: __ __ __

Billing zip code: __ __ __ __ __

Card Payment Agreement: All credit/debit/HSA card payments are charged remotely, after services have been rendered. I understand that my card may be charged anytime from immediately after a service until the expiration of my card. I am legally authorized person to use this card to pay for services.

General Financial Agreement: I understand that I am financially responsible for services not covered by my insurance, including a $70.00 fee for any missed appointments if I have not notified my provider in at least 24 hours in advance. I understand that I will be charged a late fee for unpaid co-pays/bills after 30 days. I understand that I will be billed for any consultation services between my provider and anyone I signed a release for her to speak with. I understand and authorize charges due to consultation with other providers, school personnel, and legal parties. These charges are not covered by my insurance benefits.

Client Signature:_____ Date:_____

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Sliding Scale & Non-Covered Fees 2022

Uninsured/ Out-of-pocket rates based on recent tax return:
If you feel that you qualify for a discounted rate on this scale, please indicate which income bracket best reflects your financial situation. Your signature is required, even if you are *not* paying for services out-of-pocket.

Family Size: 1-3 Members	Family Size: 4+ Members	Initial Intake:	45-min session:	60-min session:	75-min sessions:	90-min session:
0- $35,000	0- $45,000	$115.00	$70.00	$95.00	$125.00	$140.00
$35- $60,000	$45- $70,000	$145.00	$95.00	$120.00	$155.00	$175.00
$60- $85,000	$70- $95,000	$175.00	$120.00	$145.00	$185.00	$210.00
$85- $110,000	$95- $120,000	$205.00	$145.00	$170.00	$215.00	$245.00
$110,000- $210.00	$120,000- $220,000	$235.00	$170.00	$195.00	$245.00	$280.00
$210,000+	$220,000+	$310.00	$240.00	$310.00	$310.00	N/A

Additional services not typically covered by insurance:

Late Cancellation (within 24 hours)/Missed Appointment:	$70.00 _____ *(please initial)*
Late Payment /per 30 days:	$10.00
Documentation Preparation:	$70.00
Lending Library- lost or kept book (kept over 30 days):	$25.00
Phone Consultation with Provider/Attorney/School:	0-30 min/ $70.00
Phone Consultation with Client/Parent:	0-10 min/ no charge 10-45 min/ session rate
Out-of-office Service (ex. hospital, court, school):	45 min/ $270.00 90 min/ $380.00
In-office Session w/ 2 clinicians:	45 min/ $340.00 90 min/ $560.00
Out-of-office Service w/ 2 clinicians:	45 min/ $540.00 90 min/ $760.00

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