SNBCare
Spectrum Neuro Behavioral Care

Patient Registration Form

DOB: ______ Patient Age: ______

Name: ______ Sex: ______

Preferred Pronouns: ______

Address: ______

Height: ______ Weight: ______ Phone Number: ______

Cell Phone Number: ______ Email: ______

Preferred Contact Method: ○ Email ○ Phone ○ Cell/Text ○ Portal only

Preferred Reminder Method: ○ Email ○ Phone ○ Cell/Text ○ Portal only

Occupation: ______

Race: (optional)

Insurance Information

Primary Insurance Name: ______ Insurance ID: ______

Name of Insured: ______ Relationship to Patient: ______

Secondary Insurance Name: ______ Insurance ID: ______

Name of Insured: ______ Relationship to Patient: ______

Primary Care Information

Name of Physician : ______ Phone Number: ______

Address: ______ City, State, and Zip: ______

Pharmacy: ______ Phone Number: ______

Address: ______ City, State, and Zip: ______

Current Medications:

(Please list all medications including over-the-counter medications and supplements. Please continue on back if needed.)

Name	Dosage	Frequency	Date Started

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Previous Medications:

Name	Dosage	Frequency	Date Started	Date Finished

Emergency Contact Information

Please be aware that we will only contact your emergency contact the in case of an emergency. Your emergency contact is not authorized to speak on your behalf and we are not able to disclose information to your emergency contact outside of an emergency. If you would like someone to be able to speak on your behalf, schedule appointments for you, or otherwise have access to your information, please complete a separate consent to release with their information.

Name of Contact: ____ Phone Number: ____

Relationship to Patient: ____

Patient's Allergies: ____

Have you been psychiatrically hospitalized or hospitalized for substance abuse within the past five years? (please circle one) ○ Yes ○ No

If yes, please indicate the name of the treatment facility and complete the attached consent to release for that institution: ____

Dates hospitalized: ____

Are you currently enrolled in a methadone or substance abuse treatment program? (please circle one) ○ Yes ○ No

If yes, please indicate the name of the treatment facility ____

Dates hospitalized: ____

Please send copy of your ID and Insurance Card by one of the following method:

1. Send photocopy of ID and Insurance Card by mail.
2. Send a text message of your ID and Insurance Card picture to 781-666-2711.
3. Attach it to a message sent on Patient Portal.
4. Upload a picture of the front and back of your insurance card to the patient portal.

Patient Signature:

Date: ____

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Patient Practice Agreement:

Patient Name: Date:

Authorized Representative:

If an authorized representative is required due to patient incompetence, I acknowledge that I am responsible to act on behalf of the patient and all information stated towards a patient of SNBCare in any documentation is applicable to me as the authorized representative of the stated patient. I understand that I must provide Spectrum Neuro Behavioral Care with accurate legal documentation reflecting this authorization.

Authorized Representative Initials: Relationship to the patient:

Participation in and Consent to Treatment:

I consent to be a patient under the treatment of SNBCare and confirm that I am a voluntary participant. I understand that I am an active participant in my treatment and have the right to ask any questions pertaining to my treatment, including different therapeutic interventions, medications (including their side effects) and/or procedures used for my health. I understand that I have the right to participate in the development of my treatment plan, including the discussion of the nature of my medical condition, the proposed treatment plan, the expected duration of treatment , the probability of successful outcome, and any alternative treatment(s) if any are available.

I understand that urine/drug screen testing may be requested by my provider at any time and that refusal may impede treatment. I understand that I have the right to voice any concerns related to my treatment with my provider at any time. I understand that failure to comply with SNBCare related policies or inability to develop an agreed upon treatment plan may result in discharge from my treatment.

I understand that I have the right to revoke my consent/authorization to treatment at any time by submitting a form to SNBCare's Privacy Officer.

Patient/ Representative Initials:

Patient Protected Health Information Confidentiality and Rights:

I understand that the information contained in my medical record will remain confidential as permitted by state and federal laws/regulations.

I understand that I have the right to obtain a copy of my protected health information that is contained in my medical record for as long as SNBCare maintains the protected health information. To obtain my medical information, I will submit a written request to SNBCare's Privacy Officer. I understand that SNBCare may charge me a fee for the costs of copying, mailing, or other costs incurred in complying with my request.

I understand that SNBCare may deny my request to obtain a copy of my protected health information if, in SNBCare's professional judgment, it is determined that the access requested is likely to endanger my life/safety or that of another person, or that it is likely to cause substantial harm to another person referenced within the information. I also understand that I have the right to request a review of this decision.

I understand that I have the right to request an amendment to my medical information if I believe that SNBCare's medical information about me is incorrect or incomplete. I will make this request by completing the SNBCare Patient Amendment Request form. I also understand that in certain cases, SNBCare may deny my request for an amendment.

I understand that my records and any information pertaining to me will not be released without my written consent or the consent of my authorized representative. I consent to giving SNBCare the permission to share records with and discuss my medical condition with my other caregivers including but not limited to the providers of SNBCare and other individuals employed by SNBCare and that are involved in my care. I understand that such communication is for the coordination of treatment.

I acknowledge that I have read a copy of SNBCare’s Notice of Privacy Practices and Patient Information. I understand that I have the right to ask any questions related to such practices and office policies at any time. By signing below, I understand and acknowledge that I have received the above information and that any questions have been answered to my satisfaction.

Patient/ Authorized Representative Signature:

Relationship of Authorized Representative:

SNBCare
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Financial Policy

Patient Name: Date of Birth:

As a patient of SNBCare, I understand that paying my bill is a part of my treatment process and it is important that I understand the following:

- SNBCare provides me an estimated patient responsibility before my appointment. But I do understand that this is an estimated financial responsibility and final determination can only be calculated once the claims are processed from my Insurance.
- I do take complete financial responsibility of the amount applied by my insurance.
- Co-pays must be paid at the time of my visit. SNBCare accepts payment in the form of cash, checks and/or credit cards.
- Deductibles and co-pays are the responsibility of the patient and must be paid. I understand that payment arrangements can be made based on financial need.
- In order to prevent co-pay balances from accruing, any unpaid co-pay must be paid no later than my next follow up visit.
- I may be charged a fee of $20 for reprocessing returned checks due to insufficient funds.
- It is the patient's responsibility to provide accurate insurance information, including any secondary insurance, at the time of the patient visit.
- If my insurance requires a referral from my primary care physician, it is my responsibility to obtain this referral.
- If applicable, SNBCare reserves the right to reschedule any appointments if there is no valid referral for the date of service.
- SNBCare reserves the right to reschedule an appointment if my insurance is inactive on the date of service.
- Medicare requires a 20% co-insurance at the time of the visit unless the patient holds secondary insurance.
- If patient's insurance company fails to pay the medical bill within 90 days due to reports of inaccurate information or non-covered service, the bill will be transferred to the patient.
- For requested printed paperwork, letters or other documentation, a minimum fee of $5 will be charged.
- If I do not have insurance, SNBCare has payment options available as it is very important that payments be made on a consistent and timely basis to avoid any disruption of service.
- If payments have not been received as per the payment schedule agreement or if the account has outstanding payments for 90 days, patient account information will be turned over to a collections agency, unless prior arrangements have been made.
- In the event that a patient fails and/or refuses to make all payments due to SNBCare, treatment may be interrupted or placed on hold until the balance is paid in full.
- If a patient fails/refuses to pay a balance, the patient shall be responsible for all costs of collection.

I have read SNBCare's Financial Policy and by signing below, I indicate that I understand and agree to comply with the policy. I understand that failure to comply will result in interruption of my treatment until my account is in good standing.

Patient/ Authorized Representative Signature:

Date:

Relationship of Authorized Representative:

SNBCare
Spectrum Neuro Behavioral Care

Office Attendance Policy

Spectrum Neuro Behavioral Care (SNBCare) has an attendance policy to monitor and ensure that patients regularly attend their scheduled appointments for an overall successful treatment experience. The consistency of attending appointments assures that medication will not be interrupted and/ or that your therapy goals are being met.

In signing this form, you are indicating that you understand the attendance policy and will adhere to the following:

1. In order to cancel an appointment, I agree to call the office number (during business hours of 9AM to 5PM, Mon-Fri) at least 24 hours prior to my scheduled appointment. I understand that if I do not adhere to the cancellation policy, this will be considered a no-show. Emergencies will be taken into consideration.
2. I understand that I will be requested to reschedule my appointment within 7 days of canceling.
3. I understand that canceling or no-showing for an appointment could result in the interruption of medication.
4. I agree to notify the office, if capable, if I have been hospitalized or if I will be unavailable for extended periods of time (i.e. vacation). I will do my best to have the hospital provide a discharge summary to Spectrum Neuro Behavioral Care if I am hospitalized.
5. I agree to notify my provider if I am choosing to terminate services in order for future appointment(s) to be cancelled.
6. I understand that if I do not arrive (log on) on time for my appointment, I may not be able to seen for my scheduled appointment and may be asked to reschedule.
7. **I understand that I will be responsible for a no-show fee if I don't show up to my appointment and I don't notify SNBCare 24 hours in advance.**

Appointment Type	No-Show Fee	Appointment Type	No-Show Fee
Initial Medication Management Appointment	$75	Follow Up Medication Management Appointment	$75
Initial Therapy Appointment	$75	Follow Up Therapy Appointment	$75
TMS Mapping/Re-Mapping Appointment	$50	TMS Follow Up Appointment	$50

This policy also states that patients may be discharged from the practice for any of the following reasons:

- 4 missed appointments within a 6 month period.
- Behaving inappropriately toward providers and/or administration staff.
- Noncompliance with medication/treatment plan.

If you are discharged from the practice, any readmission to the practice will require approval by the Director of Operations.

I have read the above Attendance Policy and understand that my cooperation and active participation in following these guidelines will greatly facilitate the quality of treatment.

Patient/Authorized Representative Signature:

Date:

COPY AVAILABLE UPON REQUEST

SNBCare Telehealth Policy for Patients

This document is your consent to receive telehealth services through SNBCare (Spectrum Neuro Behavioral Care). Telehealth service is the delivery of healthcare services when the healthcare provider and the patient are not in the same physical location/site through the use of various technologies.

Potential Risks

As with any medical procedure, there are potential risks associated with the use of Telehealth. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g., poor resolution of images) to allow for appropriate medical decision-making by the practitioner.
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment. In the event that there is equipment or technological failure during a Telehealth encounter, you should call SNBCare to receive follow-up or ongoing care.
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgment errors.
- As telehealth sessions take place outside of your provider's office at SNBCare, there is potential for other people to overhear sessions if you are not in a private place during the session. On the practice's end, reasonable steps will be taken to ensure your privacy using network and software security protocols. It is important; however, for you to make sure you find a private place for appointments where you will not be interrupted. It is also important for you to protect the privacy of your appointment on your cell phone or other device. You should participate in therapy only while in a room or area where other people are not present and cannot overhear the conversation.

To participate in telehealth services, you understand that you will need a computer or tablet device with a camera for video conferencing, speakers or headphones, a phone with active service, and a good internet connection or good telephone reception.

It is important that you understand, acknowledge, and agree to the following statements:

- I understand that I am agreeing to participate in a HIPAA compliant telehealth encounter that will contain my personal information as well as my medical information. I understand that it is my obligation to notify my provider of any other persons in the location, either on or off camera and who can hear or see the session. I understand that I am responsible to ensure privacy at my location. I will notify my provider at the outset of each session and am aware that confidential information may be discussed.
- I understand that there are limitations in the provision of medical care and treatment via telehealth services and that I may not be able to receive a diagnosis and/or treatment through telehealth services for every condition possible. I understand there are potential risks to using telehealth technology, including but not limited to, interruptions, unauthorized access, and technical difficulties. I understand some of these technological challenges include issues with software, hardware, and internet connection which may result in interruption.
- A Provider may determine in his or her sole discretion that my condition is not suitable for diagnosis and/or treatment using the telehealth services, and that I may need to seek medical care and treatment with a specialist or other healthcare provider, outside of the telehealth services offered at SNBCare.
- I understand that the provider will not be in the same location as me for our appointment. I understand that because the healthcare provider may be distant and/or unfamiliar with the local area, they may be unable to provide adequate emergency assistance. In case of a crisis or emergency situation arising in which someone is in danger, I agree to take whatever precautions and steps necessary to maintain safety, including calling 911 and/or going to the nearest emergency room.

- I understand that it is my obligation to notify my provider of my location at the beginning of each treatment session. If for some reason, I change locations during the session, it is my obligation to notify my provider of the change in location.
- I understand that it is my responsibility to make conditions or symptoms known to the provider as well as to make arrangements for follow-up care in a timely manner.
- SNBCare will not make recordings of any video or telephone encounters within my appointment with my provider. I understand that all calls with administration are recorded for quality assurance.
- I agree not to record, save, publish, disseminate, or electronically transmit any data, images, video, audio, and/or any other aspect of the telehealth and/or videoconferencing service.
- I consent to healthcare services provided which may include review of diagnostic tests, medications, examinations, and consultation on pre- or post- medical or surgical treatments considered necessary for treatment.
- I understand that using a form of communication technology other than SNBCare approved telehealth applications may compromise security protocols or cause information transmitted to be insufficient (e.g., poor resolution of images) to allow for appropriate medical decision making by the consulting healthcare provider. You should be aware that SNBCare cannot guarantee the confidentiality of any information communicated by email. Therefore, SNBCare will not discuss any clinical information by email and prefers that you do not either.
- I understand that SNBCare is not responsible for any technological problems of which my provider has no control over. I further understand that SNBCare cannot guarantee that technology will be available or work as expected.
- Consent to be Contacted (Telephone Consumer Protection Act): By providing a telephone number (landline or cellular) or other wireless device, I agree that in order for representatives of SNBCare, and/or other providers involved with the provision of telehealth services to service my account(s), or to collect any amounts I may owe, SNBCare, and/or other providers involved with the provision of telehealth services may contact me at the telephone number(s) provided which could result in charges to me by my telephone or internet service provider. I expressly consent that methods of contact may include SMS text messages, phone calls, including automated technology such as an auto-dialing device, pre-recorded messages, and artificial voice messages as applicable. This consent applies to all services and billing associated with my account(s) and is not a condition of receiving telehealth services.
- I recognize my provider may need to notify emergency personnel in the event he/she feels there is a safety concern, including but not limited to, a risk to self/others or my provider is concerned that immediate medical attention is needed.
- I understand that telehealth appointments are held to the same standards as in-person appointments. I understand that participating in dangerous or distracting activities such as driving, playing video games, etc. may result in my provider terminating the appointment. I understand I will have to reschedule for a time when I can give my full attention.
- **I understand that just like an in-person office visit, my provider may be running a few minutes late. I understand that I must wait for the provider to join the call, as the provider will join as soon as they are available.**
- Zoom is the technology service used to conduct telehealth video conferencing appointments. Prior to each session, I will receive an email link to enter the “waiting room” until the session begins. There are no passwords or login required to access the appointment.
- SNBCare is NOT an emergency service. In the event of an emergency, I will use a phone to call 9-1-1 and/or other appropriate emergency contact.
- I understand that the same fee rates apply for telehealth as apply for in-person treatment. It is my obligation to contact my insurer before engaging in telehealth to determine if there are applicable co-pays or fees which I am responsible for. Insurance or other managed care providers may not cover telehealth sessions. I understand that if my insurance, HMO, third-party payor, or other managed care provider do not cover the telehealth sessions, I will be solely responsible for the entire fee of the session.

- I have been given the opportunity to ask SNBCare questions about my telehealth encounter, security practices, technical specifications, and other related risks.

I certify that I have read or had read and/or had this form explained to me; that I fully understand its contents including the risks and benefits of telehealth services; and that I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

I acknowledge that I have read this form and I understand its contents and agree to all of the provisions contained herein. I understand that violations of this policy may result in termination from the practice.

Patient/Representative Signature:

SNBCare
Spectrum Neuro Behavioral Care

Authorization to Disclose/Receive Healthcare Information

Name: ______ Date of Birth: ______

By signing below, I hereby authorize disclosure of information in the medical record of the patient identified above which includes information that may be stored in a paper and/or electronic format. Such record may contain information on demographics; financial/insurance information; general medical care; alcohol and drug abuse treatment; psychiatric treatment; behavioral or mental health treatment; HIV or AIDS; AIDS-related treatment; sexually transmitted diseases or infections; venereal disease; tuberculosis; hepatitis. Disclosure shall be limited between the listed entities and to the information obtained during the course of treatment.

☐ I hereby authorize SNBCare to disclose information to the below party. ☐ I hereby authorize SNBCare to obtain information from the below party.

A release form needs to be filled out for each institution and/or individual you would like information obtained from and/or send to. If you have been recently hospitalized, please ensure you complete a consent to release with that facility's information.

Please provide the information of who you are authorizing below. This can be your PCP/therapist/hospital/an individual/etc. Without their information, this release is not valid.

Spectrum Neuro Behavioral Care	Name: ______
	Address: ______
Tel: 781-666-2711 | Fax: 781-666-2712	Telephone: ______
	Fax: ______

Please check the box(es) to indicate if we may release information below (if it is in your medical record):

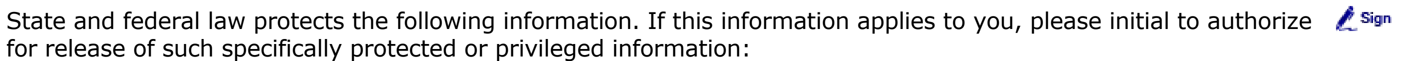
☐ Psychiatric evaluation/Mental status ☐ History & Physical ☐ Referral Information ☐ Medical Consultation ☐ Laboratory/Pathology results ☐ Discharge summary/instructions ☐ Psychological test results ☐ Treatment Plan ☐ Neurological test results ☐ Progress notes ☐ Financial account information

☐ Other: ______

Please check the box(es) which indicate the purpose of disclosing the information you agree to be released:

☐ Medical care ☐ Insurance/payment ☐ Legal matters ☐ Vocational purposes ☐ Coordination of care ☐ Referral purposes ☐ Family involvement

☐ Other: ______



State and federal law protects the following information. If this information applies to you, please initial to authorize for release of such specifically protected or privileged information: Sign

☐ Alcohol and/ or substance abuse record ☐ Domestic violence counseling ☐ HIV/ AIDS testing, results and record ☐ Sexual assault counseling ☐ Mental health record ☐ Genetic testing

The dates of service being requested are from the time period treatment occurred, unless specifically limited to the dates specified as follows: Dates of Service

Disclosure format

Fax or paper/US mail is default if not marked. Specify email or other electronic format:

- Authorization is valid only if received within 90 days of being signed and expires within one year from date of signature or if services are terminated prior to the one year or if otherwise specified:
- I may revoke this authorization at any time by submitting a written request. Revocation will not apply to information disclosed prior to receiving notification of revocation.
- I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal and state privacy laws.
- I have a right to request a copy of this authorization.
- I understand that I have the right to refuse this authorization and treatment will not be contingent on signing this authorization.
- I have carefully read and understand this authorization and have had any questions answered to my satisfaction. By signing below I do hereby expressly and voluntarily authorize disclosure of the above information regarding my health to the persons or agencies listed above.

Patient Signature/ Legal Representative:

Date:

Relationship to patient, if applicable:

SNBCare
Spectrum Neuro Behavioral Care

Patient Agreement for Controlled Substance

PATIENT NAME: DATE:

I agree to the following:

- I agree to keep my medication in a safe, secure location and away from children. If the medication is lost or stolen, I understand that I will need to bring in a police report and the medication will not be replaced, if at all, until my next appointment.
- I agree to have urine or blood tests as directed. I understand that testing positive for any illicit drugs or any medication that is not being prescribed to me is a violation of this agreement.
- I agree to not sell or share my medication with anyone else.
- I agree to keep all my scheduled appointments. If I am not able to attend, I will provide 24 hour notice and will reschedule within seven days. I understand I will not get my medication called in for more than 7 days.
- I agree to take my medication only as prescribed and will not take more unless I have addressed it with my provider and it has been approved.
- I agree to notify my provider of any new medication that is prescribed by another doctor, including suboxone or methadone.
- I will treat the staff at the office respectfully at all times. I understand that if I'm disrespectful to staff or disrupt the care of other patients that my treatment may be stopped.
- If I am on high doses of a controlled substance, I agree to slowly and safely reduce dosage as per the guidance of my provider.
- I understand that my provider is under no obligation to continue prescribing any controlled substance medication if I do not attend follow-ups as scheduled.
- I understand if I am on controlled substances, I will be seen monthly by my provider.

Refills

Refills will be made only during regular office hours and 72 hour notice must be provided. There will be no refills after office hours, weekends, or during holidays.

Termination of Agreement

I understand that if I do not adhere to this office policy, this medication may be stopped in a safe way. I understand that if I do not adhere to this office policy, controlled substances may not be refilled by my provider.

Patient Signature:

Date:

(781)666-2711
(781)666-2712
Info@SNBCare.com
www.SNBCare.com

SNBCare
Spectrum Neuro Behavioral Care

Symptom Review

Name: ____________ Date of Birth: ____________

Presenting symptoms: please check any symptoms below that you are currently exhibiting or have in the past.

Anxiety		Anger	
Depression		Panic Attacks	
Elevated mood		Nightmares	
Sleep Disturbances		Flashbacks	
Appetite Disturbances		Paranoia	
Racing Thoughts		Auditory Hallucinations	
Irritability		Visual Hallucinations	
Lack of Energy		Obsessions	
Lack of Motivation		Compulsions	
Concentration Impairments		Excessive Energy	
Substance Abuse		Changes in Sex Drive	

Have you been treated in the past for any of the following? (Please check all that apply.)

☐ Major Depressive Disorder ☐ Bipolar Disorder ☐ Anxiety/Panic Disorder ☐ ADHD (Attention-Deficit/Hyperactivity Disorder) ☐ Schizophrenia ☐ PTSD (Post Traumatic Stress Disorder) ☐ OCD (Obsessive Compulsive Disorder) ☐ Eating Disorder ☐ Substance Abuse Disorder ☐ Other (Please Explain)

Are your symptoms impairing any of the following? (Please check all that apply.)

☐ Personal Hygiene ☐ Daily Activities ☐ Job Performance ☐ Relationships ☐ Leaving the Home ☐ Other (Please Explain)

SNBCare Documentation Policy

The only documentation regarding your health or illness required by law (and included in the office visit charge) is an office visit note. Completing paperwork for any leave from work, Family Medical Leave Act (FMLA) claims, longterm care, life insurance, the Department of Veterans' Affairs, disability claims or other purposes is unnecessary duplication and goes beyond routine medical care. Therefore, it cannot be billed to your insurance company.

Since all forms require the provider's signature, they are personally responsible for the accuracy of the information provided. Incomplete or inaccurate information may have farreaching consequences for your case. For this reason, you must be a patient of SNBCare for at least six months before any documentation will be completed. Filling out forms requires careful consideration and a considerable amount of the provider's time.

Therefore, it is our office policy to charge for the completion of any form. You can avoid being charged for the form completion by requesting that the requester accepts a copy of the office visit note in lieu of a form. (For example, there is no requirement to use the FMLA form by employers. The employer just needs to know that the medical condition is real and qualifies for FMLA leave.) We can send to the designated recipient a copy of the last office note free of charge. If you wish us to do so, please fax us a signed Consent to Release with the relevant party's information.

By signing below, I understand the following with regard to additional documentation:

1. I understand that I must be seeing my current treating provider for a minimum of 6 months in order for my provider to fill out any paperwork.

2. I understand that completion of any forms will incur a $65 charge.

3. I agree to make the payment for my documentation visit before my visit with the provider and understand that failure to do can result in cancellation of my appointment.

4. I understand that an appointment is required to fill out the documents with the provider to ensure accuracy, subject to provider availability.

5. I understand that paperwork will not be completed if it has been longer than 3 months since the last appointment with my treating provider.

6. I understand that paperwork will not be completed if all sections of the form to be completed by the patient are not filled out prior to SNBCare receiving the form.

Patient Signature: Date