Lucy Barts, MD.
470 Atlantic Avenue, Suite 400
Boston, MA 02210
T (857) 361-8453
F (617) 273-8001

Your Name:_____ Birth Date: _____Today's Date_____

Street/ Apt #: _____City: _____ State: _____ ZIP: _____

Home Phone: _____ Mobile Phone : _____

Email*: _____

*Provision of email contact constitutes permission to communicate by email. Please note, confidentiality cannot be guaranteed for email communication.

Employer or School: _____

Job Title/ Position: _____

Emergency contact: _____Relationship: _____

Phone: _____

Primary Care Doctor:_____ Phone:_____

Referred by: _____

Mental Health Provider/s:_____

CONFIDENTIALITY

All information between doctor and patient is held strictly confidential unless: 1. Patient authorizes release of information with signature. 2. Patient presents a physical danger to self or others; 3. Child/elder abuse or neglect are suspect. In the later two cases I am required by law to inform potential victims and legal authorities so that protective measures can be taken. Please see the relevant federal and state HIPAA regulations.

CONSENT FOR TREATMENT

I authorize and request that my doctor carry out mental health exam, treatments, and diagnostic procedures, which are advisable now or during the course of my care. The purpose of these, alternatives and potential adverse affects will be explained to me and subject to my agreement. I also understand that while the course of therapy is designed to be helpful it may at times be difficult and uncomfortable.

FINANCIAL TERMS

Payment is expected at the time of your session in cash or check. Insurance is not accepted directly in this practice. Patients are encouraged to contact their insurance co. to discuss their out-of-network benefits, as plans sometimes reimburse a significant percentage of treatment costs. Monthly itemized receipts will be provided for out-of-network insurance claims for patients to collect reimbursement.

CANCELLED/MISSED APPOINTMENTS

A scheduled appointment means that my time is reserved only for you. If an appointment is missed or cancelled with less than forty-eight (48) hours notice, you will be billed directly according to the scheduled fee. In an emergency such as a severe snowstorm, accident, or hospitalization the fee is waived if we both agree that there was no way for you to notify the office and that the event constitutes an unforeseeable emergency.

If two (2) consecutive appointments are missed or cancelled, before rescheduling, we will have to discuss your treatment goals and whether you are able to commit yourself to treatment at this time. If at some point you decide not to continue in treatment with me, please call my office and leave a message, especially if you have appointments scheduled. Thank you!

I understand and agree to all of above information.

Name-Printed:_____ **Date:**_____

Name-Signed:_____