

PERSONAL INFORMATION

Name _____ Date _____

Preferred name (if different) _____ Pronouns (optional) _____

Street address _____

City _____ State _____ ZIP code _____

Phone _____ Email _____

Date of birth _____ Relationship status _____

How did you hear about me? _____

Preferred contact ☐ Phone ☐ Text ☐ Email

INSURANCE INFORMATION *Complete only if you need a superbill for insurance reimbursement.*

Insurance company _____

Insurance ID _____ Gender (per insurance) _____

Insured's name (if not self) _____ Relationship _____

Insured's date of birth _____

EMERGENCY CONTACT☐ I don't have an emergency contact

Name _____ Relationship _____

Phone _____

HEALTH INFORMATION

Primary care provider _____ Phone _____

Primary care email _____

Psychiatrist / Prescriber _____ Phone _____

Psychiatrist / Prescriber email _____

Date of last physical _____

Physical complaints / illnesses / allergies _____

MEDICATIONSPlease list *all* medications.**FOR PROVIDER USE**

Date of intake _____ DX / Code _____ Fees _____

PRACTICE POLICIES

Please take a moment to review these practice policies. I'm happy to talk through any questions with you.

CONTACT AND COMMUNICATION

Phone | Text: 617-470-5404

Email: brett@brettpsych.com

Fax: 855-614-3271

You're welcome to reach me by phone, text, or email for scheduling and administrative questions. Text messages may not be secure; please avoid sharing clinical information by text. I typically respond the same day, though occasionally it may take up to two business days. Messages are not monitored continuously.

PAYMENT AND INSURANCE

Payment is due in full at the time of each session. Accepted payment methods are cash, check, credit card, Venmo, or health savings account (HSA).

I do not accept insurance. Upon request, I can provide a superbill for you to submit to your insurance plan for possible reimbursement.

FEES

Fees are agreed upon before treatment begins. You will receive advance notice of any fee increase. The following fees apply to 50-minute sessions:

SERVICE	INDIVIDUAL	COUPLES
Ongoing sessions	\$250	\$275
Initial intake session	\$275	\$295

Requested letters, forms, and other work outside sessions are billed at **\$250 per hour**, prorated for the time involved.

Please give at least two business days' notice when cancelling or rescheduling. See the Cancellation and Payment Policy for full details.

URGENT AND EMERGENCY SUPPORT

Please do not wait for a response from me if you need immediate help.

Crisis support: Call or text **988** for mental health or substance use crisis support, available 24 hours a day.

Immediate danger or a medical emergency: Call **911** or go to the nearest emergency department.

I understand and agree to the above policies.

Signature _____

Date _____

YOUR RIGHT TO A GOOD FAITH ESTIMATE

A Good Faith Estimate is a written statement of the total expected cost of planned non-emergency care, including related charges.

WHO THIS APPLIES TO

These rights under the No Surprises Act apply to planned non-emergency care if you have no insurance benefits for these sessions or choose not to seek reimbursement.

Superbill reimbursement: If you have benefits for these sessions and plan to submit a claim, these uninsured/self-pay estimate rights generally do not apply.

WHEN YOUR ESTIMATE IS DUE

Care booked 3-9 business days ahead: Within 1 business day of booking.

Care booked 10+ business days ahead: Within 3 business days of booking.

Estimate requested before booking: Within 3 business days of your request.

IF YOUR BILL EXCEEDS THE ESTIMATE

If a provider bills you \$400 or more above the estimate from that provider, you may qualify for the federal patient-provider bill dispute process. Keep a copy of your estimate for your records.

QUESTIONS AND HELP

To request an estimate or ask about treatment costs, contact me at 617-470-5404 or brett@brettpsych.com.

For information about your rights or help with a bill dispute:

No Surprises Help Desk: 1-800-985-3059

cms.gov/nosurprises/consumers

NOTICE OF PRIVACY PRACTICES

Effective date: October 5, 2026

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your privacy matters to me. I will take every reasonable precaution to protect the personal information you share with me. I will never sell your personal information. Information is shared with your permission or when the law allows or requires it. I also follow stronger state privacy protections.

YOUR RIGHTS

- You can ask to see or receive copies of your clinical and billing records, on paper or electronically. Limited legal exceptions include separately kept psychotherapy notes. Any copying fee must follow applicable law.
- You can ask for corrections if your record is inaccurate or incomplete. If I cannot make a requested change, I will explain why in writing. You may add a statement of disagreement to your record.
- You can ask me to contact you at a different number or address. I will accommodate reasonable requests.
- I will consider requests to limit how your information is used or shared, although I may not be able to agree. For a service paid in full out of pocket, I must honor your request not to share its information with your health plan for payment or practice operations, unless required by law.
- You can request a list of disclosures over the past six years. Legal exceptions include treatment, payment and practice operations. One list per 12 months is free; extra lists may have a reasonable fee.
- You can ask for a paper copy of this notice at any time, even if you received it electronically.
- Someone legally authorized to act for you may exercise these rights. I will confirm their authority.
- You can file a privacy complaint with me or HHS. Your care will not be affected. Contact details appear on the next page.

HOW I PROTECT YOUR PRIVACY

I am required by law to safeguard your health information, follow this notice and provide you with a copy. If a breach affects its privacy or security, I will notify you as required by law.

Certain substance use treatment records have extra protections under federal law (42 CFR Part 2). If I receive those records, they and testimony about them cannot be used or shared in investigations or legal proceedings against you without your written consent or a qualifying court order and subpoena.

If this notice changes, the updated version may apply to information I already hold. A copy will be available in my office, on my website, or by request.

PRIVACY PRACTICES - CONTINUED

HOW I USE AND SHARE INFORMATION

- Your care: I use information to understand your needs and plan our work together. With appropriate permission, I may coordinate with another provider involved in your care.
- Payment: I use billing information to process payments and prepare a superbill upon request, including service details and a diagnosis when applicable.
- Practice support: I use information to maintain records, review the quality of care and send appointment reminders. Service providers who assist me must follow applicable confidentiality requirements.

In certain situations, the law permits sharing for public health, reporting abuse or neglect, serious and imminent safety concerns, oversight, approved research, workers' compensation, law enforcement, certain government functions, organ donation, or work by coroners and funeral directors. I follow the legal requirements for each situation.

I review court orders and subpoenas carefully and follow the legal protections for confidential therapy communications. I must also share information when required by law, including HHS privacy reviews.

YOUR PERMISSION

Your written authorization is required for most sharing of separately kept psychotherapy notes, for using your health information for marketing, and for uses not described here. You can withdraw authorization in writing at any time. This does not undo actions already taken with your permission.

You decide whether I share relevant information with family or others involved in your care or payment. If you cannot communicate your wishes, I may share limited information in your best interest, when allowed by law.

QUESTIONS AND CONCERNS

Please bring privacy questions or concerns to me. For written rights requests or complaints, contact Brett P. Terrien (privacy contact): 617-470-5404 or brett@brettpsych.com.

You can also file a complaint with the HHS Office for Civil Rights at 1-877-696-6775 or at the website below. Your care will not be affected, and there will be no retaliation.

hhs.gov/hipaa/filing-a-complaint

ACKNOWLEDGMENT OF RECEIPT

I acknowledge that I have received this Notice of Privacy Practices.

Signature _____

Date _____

CANCELLATION AND PAYMENT POLICY

I look forward to working with you. I'm happy to talk through any questions about these policies.

APPOINTMENTS AND CANCELLATIONS

Your appointment time is set aside for you. Please give at least two business days' notice by phone, text or email to cancel or reschedule. This helps me offer the time to another client looking for an appointment.

Business days are Monday through Friday, including holidays.

For Monday appointments, please cancel by 5:00 PM on the preceding Thursday.

Appointments cancelled with less than two business days' notice, or missed without notice, are charged at the full session fee. Rescheduling does not automatically waive this fee.

I know plans can change unexpectedly. This policy applies to late cancellations and missed appointments for any reason, including illness, weather or scheduling conflicts.

Initials I understand the cancellation policy.

PAYMENT AND CARD ON FILE

Payment is due at each session. Please provide a current credit or debit card to secure your appointment and arrange payment for in-person or Zoom sessions. Let me know if your card details change.

Unless we have made other arrangements, I will charge the card you provide for session fees and for late cancellations or missed appointments under the policy above.

Initials I authorize the card charges described above.

Name on card

Card type ☐ Mastercard ☐ Visa ☐ Discover ☐ American Express

Card number

Expiration date Billing ZIP code

For security, I'll ask for your card's security code at our first appointment.

I have read and agree to this cancellation and payment policy.

Signature Date