

Nat Kuhn, MD

5 Watson Rd.
Belmont, MA 02478

617-489-9090

www.natkuhn.com
nk@natkuhn.com

To: New patients of Dr. Kuhn

Please read and complete the following forms:

- The two-page New Patient Information Form
- The Policies sheet for my practice
- Authorization forms to communicate with and/or receive records from your Primary Care Provider, previous mental health providers, and other current mental health providers, as applicable
- A form to authorization video recording of our sessions together. You do not need to authorize recording for us to work together, but there are a number of ways that it may improve the effectiveness of your treatment. If you wish to give limited consent, you may cross out any portion of the form that you are not comfortable with.

If you complete these forms after our appointment and I'm busy with another patient, you can either leave them outside my office, on the clipboard, with the forms facing the wall; or you can mail them to me.

Thank you,

Nat Kuhn

New Patient Information

Date: ___ / ___ / _____

Name	First	MI	Last
Address	Apt #		
City	State	Zip	
Sex	<input type="checkbox"/> Male <input type="checkbox"/> Female	Birth Date	___ / ___ / _____ SSN - -
Marital Status	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Same-Sex Union <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		
Emergency Contact	Name	Relationship	Phone () -
Primary Care MD	Name	Phone () -	
Medications			

Contact Information: Please provide your contact information. In the box to the right of "Pref," please mark "1" for your first choice of how to be contacted, "2" for your second choice, etc. If I should **not** contact you by this method, please mark "NO."

Home Phone	Pref	() -	Work Phone	Pref	() -
Cell Phone	Pref	() -	E-mail	Pref	

Employment/School Information

Employment	<input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Not Employed <input type="checkbox"/> Student <input type="checkbox"/> Disabled				
Employer or School	Name				
	Address				
City	State	Zip			

Insurance Information: Primary Insurance (if being used)

Insurance Name	Name	Address			
City	State	Zip	Phone	() -	
Subscriber ID	Group #	Policy #			
Subscriber Name	"Same" if same as patient				
Subscriber Address	City, State, Zip; "Same" if same as patient				
Sex	<input type="checkbox"/> M <input type="checkbox"/> F	DOB	___ / ___ / _____	Relation to Pt	Co-Pay

Patient's Name	Please print
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Financially Responsible Party (Who should be billed for balances? Write "same" if same as patient.)

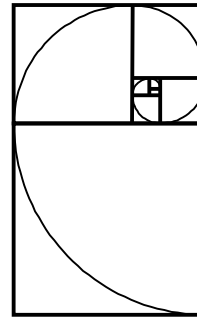
Name	First	MI	Last
Address			
City	State	Zip	Apt #

Insurance Information: Secondary Insurance (if any)

Insurance Name	Name	Address		
City	State	Zip	Phone () -	
Subscriber ID	Group #	Policy #		
Subscriber Name	"Same" if same as patient			
Subscriber Address	City, State, Zip; "Same" if same as patient			
Sex	<input type="checkbox"/> M <input type="checkbox"/> F	DOB	___ / ___ / _____	
Relation to Pt			Co-Pay	

Patient (or Guardian): Read, sign, and date **all** sections

Release of Information	I authorize Nathaniel S. Kuhn, MD to release any medical or other information necessary to process insurance claims to his billing service and to the insurance companies and/or case management organizations that are providing my mental health insurance. I also request payment of government benefits either to myself or to the party who accepts assignment below.
	Signed: _____ Date: _____
Assignment of Benefits	I authorize payment of all medical benefits directly to Nathaniel S. Kuhn, MD.
	Signed: _____ Date: _____
Patient's Responsibility for Payment	I understand that I am responsible for payment for services that are not covered by my insurance plan for whatever reason, including denial of medical necessity, late cancellations, missed appointments, same day/same charge duplication by different providers, etc. I also understand that if my balance is not paid in a timely fashion, I may liable for additional charges, such as interest, collection fees, etc.
	Signed: _____ Date: _____



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Policies

Privacy

As a physician and psychotherapist, your privacy is of the utmost importance to me. Our communications (and even the fact that you have come to see me) are confidential. My policy is to release your information only:

- to you, or as explicitly authorized by you
- as necessary for your treatment (e.g. calling a prescription to a pharmacy, or managing an emergency)
- in rare instances, as otherwise required by law (e.g. as a mandated reporter of child abuse)

If it is important to you that I communicate with you in particular ways (e.g. not to leave a message at your work number), please be sure to let me know.

With some of my patients, I make video recordings of sessions, but only with prior discussion and written consent.

My privacy policy is available on my web site (www.natkuhn.com/privacy), and I will provide you with a printed copy on request. If you have any questions or issues about privacy, confidentiality, or how I manage your information, please speak to me or contact me.

Signed: _____

Date: _____

Cancellation

If you're unable to keep your appointment, please give me as much advance notice (in person or by telephone) as you're able to. If the notice is less than 24 hours, you will be responsible for the appointment charge. Please note that insurance does not cover the cost of missed or canceled appointments. With advance notice, I am sometimes able to reschedule an appointment without charge.

Signed: _____

Date: _____

E-mail and Phone Calls

I am available by email, but email contact with me is not completely reliable. In the event of an emergency or anything requiring a rapid response, call me rather than emailing. If you email me and don't hear back within a few days, please contact me again, either by phone or email.

Because email is not encrypted, it is not possible to absolutely guarantee its privacy. By emailing me, you are consenting to me sending you email communication that may contain protected information.

Please be advised that if you ask me to call you at a number which blocks unidentified callers, I will only be able to return your call when I am in my office.

Signed: _____

Date: _____

Renewals at CVS	<p>I no longer honor requests from CVS pharmacies to renew prescriptions. If you use CVS and have no additional refills available, simply call me directly to renew the prescription.</p> <p>CVS routinely requests renewals for medications without the patient asking. If the medication has been changed or discontinued, this promotes medical errors and increased health care costs. Because CVS does not allow physicians to opt out of this system, I have reluctantly concluded that I will no longer accept their renewal requests. Should CVS change this policy, either to stop the practice or to allow individual physicians to opt out, I will again honor CVS renewal requests.</p>
Incidental Contact	<p>I sometimes run into patients by chance, e.g. on the street or at a movie theater. Because of confidentiality, I do my best to leave it up to you whether to acknowledge these encounters or not. It's OK with me when patients greet me, and it's OK with me when patients choose to ignore me in these situations.</p>

Authorization to Release Medical and Mental Health Information

Your Name	First	MI	Last
Address	Apt #		Phone () -
City	State	Zip	Birth Date ___/___/_____

I authorize the following person or facility to release and/or exchange medical and/or mental health information to/with Dr. Nat (Nathaniel S.) Kuhn:

Name	Person or Facility		
Address	Phone () -		
City	State	Zip	Fax () -

Information to be released (please **cross out** any options you do not wish to authorize):

General Authorization	For medical, mental health, drug/alcohol, HIV/AIDS, genetic information or
Particular Information Only	Specify
Communication Method	Verbal Information and Copies of Records
Reason for Disclosure	<input type="checkbox"/> Evaluation and/or Treatment <input type="checkbox"/> At my request or Specify Other Reason
Term of Authorization	<input type="checkbox"/> During my treatment with Dr. Kuhn or Expiration Date ___/___/_____

Conditions of Authorization	I understand that:	
	<ul style="list-style-type: none"> I do not need to sign this authorization, in which case no information will be disclosed. I will not be denied treatment if I choose not to sign this authorization. I am entitled to a signed copy of this authorization. I can revoke this authorization at any time, by written request to Dr. Kuhn. The revocation is effective immediately on Dr. Kuhn’s receipt of the written request, but the revocation will not affect any action taken by Dr. Kuhn prior to his receipt of the request. Dr. Kuhn’s privacy policy is available at his web site, at www.natkuhn.com/privacy 	
Signature	Signed: _____	Date: _____

Authorization to Release Medical and Mental Health Information

Your Name	First	MI	Last
Address	Apt #		Phone () -
City	State	Zip	Birth Date ___/___/_____

I authorize the following person or facility to release and/or exchange medical and/or mental health information to/with Dr. Nat (Nathaniel S.) Kuhn:

Name	Person or Facility		
Address	Phone () -		
City	State	Zip	Fax () -

Information to be released (please **cross out** any options you do not wish to authorize):

General Authorization	For medical, mental health, drug/alcohol, HIV/AIDS, genetic information or
Particular Information Only	Specify
Communication Method	Verbal Information and Copies of Records
Reason for Disclosure	<input type="checkbox"/> Evaluation and/or Treatment <input type="checkbox"/> At my request or Specify Other Reason
Term of Authorization	<input type="checkbox"/> During my treatment with Dr. Kuhn or Expiration Date ___/___/_____

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- I do not need to sign this authorization, in which case no information will be disclosed.
- I will not be denied treatment if I choose not to sign this authorization.
- I am entitled to a signed copy of this authorization.
- I can revoke this authorization at any time, by written request to Dr. Kuhn.
- The revocation is effective immediately on Dr. Kuhn's receipt of the written request, but the revocation will not affect any action taken by Dr. Kuhn prior to his receipt of the request.
- Dr. Kuhn's privacy policy is available at his web site, at www.natkuhn.com/privacy

Signature

Signed: _____

Date: _____

Authorization and Release to Record Psychotherapy

Name	First	MI	Last
Address			Apt #
City	State	Zip	Phone () -
			Birth Date ___/___/_____

I authorize Dr. Kuhn to make audio and/or video recordings of my treatment interviews. I understand that the use of these recordings will be restricted to the following purposes: (1) to be reviewed by Dr. Kuhn and me; (2) for consultation by Dr. Kuhn with colleagues to maintain and improve the quality of his treatment; (3) for research; (4) for training of mental health professionals.

This authorization shall remain in effect until Dr. Kuhn’s retirement, or until revoked by me.

Conditions of Authorization	<p>I understand that:</p> <ul style="list-style-type: none"> I do not need to sign this authorization, in which case no recording will take place. I will not be denied treatment if I choose not to sign this authorization. I am entitled to a signed copy of this authorization. My full name will not be revealed. The interviews, recordings, and any accompanying descriptive material will be used in accordance with the ethical standards of professional confidentiality for licensed mental health professionals. However, with the use of recorded material it is not possible to guarantee that I would not be identified. These recordings will not become the property of anyone other than Dr. Kuhn or me. I will not receive financial compensation for the use of these recordings. I can revoke this authorization at any time, by written request to Dr. Kuhn, and that the recordings themselves will be destroyed on my written request. The revocation is effective immediately on Dr. Kuhn’s receipt of the written request, but the revocation will not affect any action taken by Dr. Kuhn prior to his receipt of the request.
Modifications	I have crossed out or modified any aspects of this authorization that I wish to change.
Signature	Signed: _____ Date: _____