Nat Kuhn MD
68 Leonard St, Mailbox 208
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:

- ☐ A four-page New Patient Information Form
- ☐ A one-page Electronic Health Record (EHR) Information Form
- ☐ The Policies sheet for my practice
- ☐ An authorization form to communicate with and/or receive records from your Primary Care Provider, previous mental health providers, and other current mental health providers, as applicable (additional copies available on request).
- ☐ A form authorizing 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

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New Patient Information

Date: ___ /___ /_____

Name	First		MI	Last			
Address						Apt #	
City				State		Zip	
Sex	☐ Male ☐ Female		Birth Date	___ /___ /_____	SSN	- -	
Marital Status	☐ Single ☐ Married ☐ Same-Sex Union ☐ Separated ☐ Divorced ☐ Widowed						
Emergency Contact	Name			Relationship	Phone ( ) -		

Contact Information

E-Mail (optional)	Email address	
	☐ Please send e-mail reminders 48 hours before appointments ☐ Please enroll me in the secure patient portal, which allows me to view and pay bills on line, and allows for secure messaging (recommended)	
Preferred Phone	( ) -	☐ Mobile ☐ Home ☐ Work ☐ OK to leave messages ☐ Please send text reminders 24 hours before appointments
Other Phone	( ) -	☐ Mobile ☐ Home ☐ Work ☐ OK to leave messages ☐ Please send text reminders 24 hours before appointments

Employment/School Information

Employment	☐ Full-Time ☐ Part-Time ☐ Not Employed ☐ Student ☐ Disabled				
Employer or School	Name				
	Address				
City		State		Zip	

Insurance Information: Primary Insurance (if you are using insurance)

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	☐ M ☐ F	DOB	___ /___ /_____	Relation to Pt		Co-Pay	

Patient's Name	Please print

Insurance Information: Secondary Insurance (if you are using secondary insurance)

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	☐ M ☐ F	DOB	___ /___ /_____	Relation to Pt		Co-Pay	

Billing Method

Choose only one	☐ Please send statements via e-mail ☐ Please send statements via the secure portal (recommended) ☐ Please send statements via US mail

Financially Responsible Party (Who is responsible for balances? Write "same" if same as patient.)

Name	First	MI	Last		
Address				Apt #	
City		State		Zip	

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.	
	Signed: _____	Date: _____
Security of E-Mail	I consent to email communication, understanding that it cannot be guaranteed to be 100% secure. I understand that this is optional.	
	Signed: _____	Date: _____

Patient's Name	Please print

Additional Information

Who is your primary care provider? Please give name, location, and phone number.

Please briefly describe any current medical problems or significant medical history

Please list all medications and supplements you are currently taking

Please list all medication allergies you have, specifying what reaction you have and how severe it is

Please list any current prescribers other than your primary-care provider, giving names, locations, and phone numbers

Patient's Name	Please print

Please briefly describe any previous therapy, counseling, or treatment with psychiatric medications

Please describe any alcohol and/or drug use

If you have had suicidal thinking, suicide attempts, any psychiatric hospitalizations, or any thoughts/impulses/history of harming others, please describe briefly

Is there anything else you would like me to know?

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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)
- as necessary for reimbursement by any insurance you are using
- 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: _____

E-mail and Phone Calls

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

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.

When I return calls on evenings or weekends, my number shows up as "blocked" on caller ID. If your phone does not accept calls from blocked numbers, I will only be able to call you during business hours. In recent years, telemarketers no longer call from blocked numbers, so if you are expecting me to call you back and get a call from a blocked number, it is more likely to be me than a telemarketer.

Signed: _____ Date: _____

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Cancellation and Lateness

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 full appointment charge; insurance does not cover the cost of missed or canceled appointments. If the advance notice is less than 24 hours, I am sometimes able to reschedule an appointment and waive the charge.

I can only bill insurance for the amount of time I actually see you. If you are late enough that I cannot bill your insurance for a full-length appointment, you will be responsible for the difference between any partial insurance payment and the expected payment for the scheduled appointment.

Signed: _____ Date: _____

Payment and Outstanding Balances

For patients who are paying out of pocket, payment is due at the time of service. For patients using insurance, co-pays can be paid at each appointment, or I can prepare a statement at the beginning of each month. I accept cash, checks, credit cards, and various forms of electronic payment.

In order to focus on clinical work rather than collecting fees, I ask all patients to leave a credit or debit card on file with my billing system. Unless we make other arrangements, unpaid balances will be charged to the credit card. For payments due at the time of service, this charge will occur shortly after the appointment. Outstanding balances on monthly statements will be charged just before preparing the next month's statement. Significantly overdue balances may be subject to additional charges, such as interest, collection fees, etc.

I am committed to being transparent with my billing practices. If you have any questions or feel that I have made an error—as sometimes happens—please contact me. Any erroneous charges will be refunded to you or applied as a credit toward future charges, according to your preference.

Signed: _____ Date: _____

Pharmacy Renewals

Because pharmacies often generate renewal requests automatically, I no longer accept requests from pharmacies to renew prescriptions. If you need additional medication and have no refills on your current prescription, please contact me directly to renew the prescription.

I came to this policy reluctantly, and for a number of reasons. Automated renewal requests can promote medical errors. For example, I have received automated requests that are incorrect because they do not reflect dose changes or are for discontinued medications. Automated renewals also increase health care costs. Pharmacies do not allow physicians to opt out, and often do not comply with patients' requests to opt out.

Signed: _____ Date: _____

Other

Incidental Contact: I sometimes run into patients by chance, for example, 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.

Ancillary Work: In the great majority of cases, ancillary work such as dealing with insurers is relatively quick, and I do not charge for it. If a task is particularly time-consuming, I will charge for my time at my clinical rate, and do my best to inform you beforehand.

Signed: _____ Date: _____

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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	☐ Evaluation and/or Treatment ☐ At my request **or**		
	Specify Other Reason		
Term of Authorization	☐ During my treatment with Dr. Kuhn **or**	Expiration Date	___ /___ /_____

Conditions of Authorization	I understand that: • 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: _____

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Authorization and Release to Record Psychotherapy

Name	First	MI	Last				
Address		Apt #		Phone	( ) -		
City		State		Zip		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	I understand that: • 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: _____