



## Newburyport Office of Wellness, LLC

31 Green Street • Newburyport, MA 01950  
(617) 858-4194

### Welcome to Our Practice

Welcome to **Newburyport Office of Wellness, LLC**. We are honored that you have chosen us to support your emotional wellness and growth. Our mission is to provide a compassionate, safe, and collaborative environment where clients can engage in meaningful self-exploration and healing.

We value your trust and are committed to ensuring your privacy, respect, and high-quality care. Please review the following policies carefully, initial each section, and sign where indicated. These policies help us maintain clear expectations and ethical standards throughout your treatment.

If you have any questions, please don't hesitate to ask your provider — we are here to help.

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### Practice Policies and Consent for Treatment

I have read, understood, and initialed each section below to indicate my agreement.

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#### Insurance Coverage and Client Responsibility

I understand that I am responsible for being up to date on my insurance plan and coverage, including copay, deductible, and co-insurance amounts. I agree to pay my portion at the time of each session and acknowledge that I am responsible for any services not covered by insurance.



### **Assignment of Insurance Benefits**

I authorize **Newburyport Office of Wellness, LLC** to release necessary information to my insurance carrier for billing and reimbursement. I authorize direct payment from my insurance company to the practice and accept responsibility for any remaining balance, including copays, deductibles, and uncovered services.

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### **Confidentiality and Mandated Reporting**

I understand that communication with my therapist is confidential except in cases required by law (e.g., suspected abuse, neglect, threats of harm, or court orders). My therapist will inform me before any necessary information is shared and will obtain a signed Release of Information whenever possible.

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### **Professional Fees**

Private pay fees are as follows:

- Initial Assessment (60 min): **\$200**
- Individual Therapy (60 min): **\$150**
- Extended Session (90 min): **\$200**
- Group Therapy (60 min): **\$45**

I understand that these fees may change and that it is my responsibility to address any concerns promptly.

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### **Consultation and Collaboration Fees**

If my therapist engages in clinical consultation, document review, or report writing beyond 10 minutes outside of session, I understand I may be billed a prorated rate for this time, as insurance does not cover these services. My therapist will inform me before any such charges occur.



**Legal Proceedings**

If my therapist is required to participate in legal proceedings related to my case, I agree to pay **\$275/hour** for preparation, report writing, and court attendance.

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**Voicemail, Email, and Texting**

I understand that electronic communication (email, text, voicemail) cannot be guaranteed as fully confidential. By providing my contact information, I authorize my therapist to communicate via these means for scheduling and appointment reminders.

I may opt out at any time.

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**Emergency Procedures**

In an emergency, I will call **911** or go to the nearest emergency room. I understand that my therapist may not be immediately available and will provide coverage information when out of office.

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**Communication Within the Practice**

I authorize my provider to consult and communicate with other treatment team members at **Newburyport Office of Wellness, LLC** as needed for my care. A Release of Information will be provided prior to any external communication.

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**Credit Card on File**

I understand that all clients are required to have a **credit card or health spending account card** on file.

This card will be charged for copayments, deductibles, missed appointments, and late cancellations.

The **no-show / late cancellation fee** is **\$150** if less than 24-hour notice is provided.

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**Revocation**

I understand that I may revoke this agreement in writing at any time, except where action has already been taken in reliance upon it, or where obligations to insurance or financial matters remain outstanding.

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**Consent to Treatment**

My signature below indicates that I have read and understood this document, had the opportunity to ask questions, and agree to the terms of treatment outlined above. I understand that some clinicians providing services within this practice may be pre-licensed or working toward independent licensure and therefore practice under the clinical supervision of a fully licensed and qualified supervising clinician. Supervision is a standard component of professional practice and is designed to ensure the delivery of competent, ethical, and high-quality clinical care. As part of this supervisory process, elements of my treatment including clinical presentation, diagnosis, treatment planning, documentation, and medical necessity may be reviewed and discussed with the supervising licensed clinician as clinically appropriate and in accordance with applicable laws and professional standards. All diagnoses and treatment determinations may be subject to supervisory review prior to billing and documentation within the medical record. I understand that confidentiality will be maintained in accordance with HIPAA and all applicable federal and state regulations, and that supervision occurs solely for the purpose of enhancing clinical care and ensuring appropriate oversight.

**Client Name:** \_\_\_\_\_

**Client Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Parent/Guardian Signature (if under 18):** \_\_\_\_\_

**Date:** \_\_\_\_\_



## Credit Card Authorization Form

### Newburyport Office of Wellness, LLC – Credit Card Authorization

I authorize **Newburyport Office of Wellness, LLC** to charge my credit card for professional services rendered, including copayments, deductibles, and late cancellation or no-show fees (\$150 if less than 24-hour notice is provided).

This card will remain securely stored on file for billing purposes. Charges will occur only for session fees, missed appointments, or other pre-approved services.

**Cardholder Name:** \_\_\_\_\_

**Client Name (if different):** \_\_\_\_\_

**Credit Card Type:**  Visa  MasterCard  Discover  AMEX

**Card Number:** \_\_\_\_\_

**Expiration Date:** \_\_\_\_\_ **CVV:** \_\_\_\_\_ **Billing Zip:** \_\_\_\_\_

**Cardholder Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*All information is kept confidential and secure.*

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## Client Information Form

Client Name: \_\_\_\_\_ D.O.B: \_\_\_\_\_  
Parent/Guardian (if applicable): \_\_\_\_\_  
Street Address: \_\_\_\_\_ City/Town: \_\_\_\_\_  
State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_  Can leave message  Cannot leave message  
Cell Phone: \_\_\_\_\_ (To be used for scheduling only)  
Email Address: \_\_\_\_\_  
School (if applicable): \_\_\_\_\_  
PCP/Pediatrician/Psychiatrist: \_\_\_\_\_ Phone: \_\_\_\_\_  
City/State: \_\_\_\_\_  
 Ok to contact PCP?  Yes  No  
Insurance Carrier: \_\_\_\_\_ Group #: \_\_\_\_\_  
Card #: \_\_\_\_\_  
Name of Insured (if minor): \_\_\_\_\_ Parent/Guardian  
D.O.B: \_\_\_\_\_  
Referred By: \_\_\_\_\_  
How did you hear about our practice? \_\_\_\_\_

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## Release of Information (ROI)

I, \_\_\_\_\_, hereby authorize **Newburyport Office of Wellness, LLC** and my provider

Kendra Murphy, LMHC (Practice Owner)

\_\_\_\_\_

to exchange and/or release information regarding my treatment to/from the following:

**Name/Agency:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

### Purpose of Disclosure:

Coordination of Care    Legal    Medical    School    Other: \_\_\_\_\_

### Type of Information to be Released (check all that apply):

Evaluation/Summary    Treatment Notes    Medication Information

Attendance    Billing Information    Other: \_\_\_\_\_

This release will expire **one year from the date of signature**, unless revoked in writing.

**Client/Guardian Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Provider Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_