ADULT PARTIAL FAX REFERRAL FORM

*****PLEASE CALL 781-924-8203 TO SCHEDULE AN APPOINTMENT AFTER FAXING THIS FORM*****
*****ALL FIELDS MUST BE COMPLETED IN ORDER TO SCHEDULE AN INTAKE*****

Our Adult **Partial Hospitalization Program (PHP**) is a short term (1-3 week) program for adults 18 and over that runs Monday- Friday 10am to 3pm with lunch from 12:30 PM to 1PM.

Intake appointments can be scheduled via Telehealth or in person.

Telehealth allows individuals to get the services they need in the comfort of their home; sessions are not a recording or webinar, instead it is a session in real time, with real people.

Pembroke's **Partial Hospitalization Program (PHP**) provides intensive group therapy, case management and psychiatric care.

PLEASE CHECK ONE: I WISH TO SCHEDULE INTAKE THROUGH ☐ **TELEHEALTH (**ONLINE & IN REAL TIME) ☐ **IN PERSON**

Completed forms can be faxed to 781-829-7162

DEMOGRAPHIC INFORMATION			
Patient's Name:			Date:
DOB:	SSN:	Phone #:	
Primary Language:	Gender:	Marital Status:	
Address:	City:	Zip:	
Phone:	Email:		
INSURANCE INFORMATION			
Primary Insurance:		Policy #:	
Subscriber Name:		Relation/DOB:	
Secondary Insurance:		Policy #:	
Subscriber Name:		Relation/DOB:	
CLINICAL INFORMATION			
Presenting Problem(s):			
Accommodations Needed:			
Any Cognitive/Intellectual Disabilities?:			
Evaluation Date:		Is this a step down from inpt?:	
REFERRAL INFORMATION			
Name of referring agency/facility:			
How did you hear about Pembroke PHP?:			
Contact Person:		Phone number:	
Email address:			
*****INTAKE OFFICE USE ONLY*****			
Call entered into MS4? ☐ **Yes** **No**		**Date/Person:**	
Intake Appointment Scheduled ☐ Yes ☐ No		☐ **Telehealth** **In-Person**	
Date:		☐ **8am** ☐ **9am** ☐ **10am** ☐ **11am** **2pm** **3pm**	
Reminder Calls ☐ 1st ☐ 2nd 3rd		**Phone number:**	

CONSENT FOR TELEHEALTH SERVICES

What are Telehealth Services?

Telehealth services are used when our patients and their respective physicians, psychiatrists or other clinical personnel (hereafter "Clinicians") cannot be physically together for mental health evaluation needs, medication prescribing or the provision of individualized or group-level services, Telehealth services use video and audio technology to send both voice and visual images between you and the Clinicians.

How do Telehealth Services work?

All patients participating in Telehealth delivery should use their reasonable best efforts to interface with Clinicians in a private setting using a two-way, interactive device with video capability (e.g. personal computers, tablets, smartphones or other personal devices with video capability), Treating Clinicians interfacing with patients will also utilize similar equipment in private settings when delivering care. Patients participating in group-level services should use their reasonable best efforts to maintain patient privacy for all participating patients and should ensure third parties are not able overhear or view participating patient information.

Are Telehealth Services private and secure?

The interactive electronic systems used comply with federal privacy and security law and/or as otherwise directed by Health and Human Services, Office of Civil Rights and other Federal oversight agencies. However, when it comes to privacy and security with group-level services, it is the responsibility of each participating patient to ensure that while participating in the telepscyhiatric services they ensure that no third parties are present or listening to the group-level session.

What happens if I choose not to consent to Telehealth Services?

If you choose not to consent to Telehealth services, you will be provided with an onsite Clinician to provide you face-to face psychiatric services, subject to the Facility's capability to provide onsite psychiatric services.

My Rights and Responsibilities

I understand that the laws that protect the privacy and confidentiality of medical information also apply to telehealth **services.**

understand that the technology used is encrypted to prevent the unauthorized access to my private medical information or is otherwise consistent with guidance from Health and Human Services, Office of Civil Rights and other Federal oversight agencies.

I understand that in some circumstances I may only be able to provide my verbal consent to the terms of this C onsent and that verbal consent shall be documented by the Clinicians and/or the facility and shall be of the same force and effect as my written consent.

I have the right to withhold or withdraw my consent to the use of telehealth services during the course of my care at any time. I understand that my withdrawal of consent will not affect my eligibility to receive future care or treatment. I further understand that declining telehealth services may result in delays or restrictions in accessing on-site care subject to facility capabilities.

I understand that the Clinicians and/or facility have the right to withhold or withdraw this consent for the use of telehealth services during the course of my care at any time if it is determined I am not able to reasonably participate in telehealth delivery.

I understand that in the event I do not make my reasonable best efforts to ensure the privacy of other participating patients in group-level services, the Clinicians and/or facility have the right to withhold or withdraw the availability of Telehealth services to me.

I understand that the all rules and regulations which apply to the practice of medicine in the state of Massachusetts also apply to telehealth services.

I understand I may not have any face to face contact with my Clinicians, except for my telehealth services visits.

Telehealth services will not be recorded.

The Clinicians will inform me if any other person can hear or see any part of our telehealth services session before the session begins.

Patient Consent To The Use of Telehealth Services

☐ I consent to telehealth services and I have read and understand the information provided above regarding telehealth services. I have had the opportunity to ask questions about this information and questions have been answered to my satisfaction. I hereby give my informed consent for the use of telehealth services in my psychiatric care and authorize use of telemedicine in the course of my diagnosis and treatment.

Signature of Patient (or authorized signer/relationship):_____Date: _

Pembroke Hospital Partial Hospital Program
20 Winter Street, Pembroke MA 02359
781-829-7113

Patient Label

ASSIGNMENT OF INSURANCE BENEFITS/RELEASE OF MEDICAL RECORD INFORMATION

I hereby authorize that payment under my health insurance program be made directly to the hospital indicated above for any and all services rendered to me during my period of hospitalization. l further authorize any holder of medical or other information pe1taining to my treatment at Pembroke Hospital to release said information to my insurance carrier and its intermediaries for utilization management, case management and quality review. I further authorize my health insurance carrier to release information about me to Pembroke Hospital indicated above, for the purpose of utilization review and case management, including past hospitalizations: l understand that the medical record may contain any of the following: psychiatric substance abuse, sexual/physical and HIV information. I permit a copy of my authorization to be used in place of the original.

REPRESENTATION ON A CLAIM

In the event this patient appears to have lost health insurance benefits, I hereby authorize the Hospital to represent me and guarantor in all eligible claims and legal action against the said employer and insurer, and to fully cooperate with the Hospital in said claims and legal action.

VERIFICATION OF EMPLOYMENT

L hereby authorize Pembroke Hospital to contact my employer to verify group insurance eligibility.

ADMISSION FINANCIAL RESPONSIBILITY

The undersigned jointly, severally, and unconditionally agree to pay Pembroke Hospital in full. Upon demand, all charges the hospital is entitled to receive which are not covered by health insurance for services rendered. I/we further understand that if said health insurance requires pre-certification 01· prior approval (such as Benefit Management Plan or Health Management Organizations), payments of benefits may be jeopardized if these are not obtained prior to admission and that I/we may be responsible for charges incurred.

SIGNATURE OF PERSON(S) RESPONSIBLE UNDER THIS AGREEMENT

_____ _____

Signature of Hospital Representative Date **Signature of Patient or Guarantor Date**

_____ _____

Hosp Rep Signature if Patient Will Not Sign & Check Reason below: **Date**

Reason patient did not sign: ◯ **Refused** ◯ **Unable** ◯ **Other** ◯ **Gave Verbal Permission**

MEDICARE PATIENTS

L certify that the information given by me in applying for payment under Title XVIIl of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration intermediaries or carries any information needed for claims related to this admission. I request that payment authorized benefits be made on my behalf. I assign payment for any in-hospital physician charges for which Pembroke Hospital authorized to bill. I understand I am responsible for any insurance deductibles and co-insurance.

_____ _____

Patient's Chosen/Preferred & Legal Name **Signature of Patient** **Date**