Steven E. Locke, MD

10 Deer Run, Wayland, MA 01778

(508) 343-0001 Phone | (508) 213-3776 Fax

steven.locke@drstevenlocke.com | www.drstevenlocke.com

WELCOME TO THE PRACTICE

Office Location:	10 Deer Run, Wayland, MA 01778
Directions to office:	See practice website at www.drstevenlocke.com
Parking:	Between garage and woodshed
Office entrance:	Brown door at the end of flagstone path. Ring bell and enter.
Privacy policies:	Enclosed, and also available at the website (Resources / Forms)

Welcome to my practice. Enclosed, please find information regarding my clinical services, fees and billing information, and some forms and questionnaires.

Please complete the enclosed forms. If we are meeting by telehealth, you can mail or fax them; if in person, bring them with you to your first appointment:

- ☐ Patient Registration Form
- ☐ Financial Agreement
- ☐ Acknowledgement of Receipt of Notice of Privacy Practices
- ☐ Telehealth Consent Form
- ☐ Email and Text Consent Form
- ☐ Consent for Use of Medication Form
- ☐ Questionnaire for New Patients

Also attached for you to read:

- ☐ Notice of Privacy Practices
- ☐ Practice Procedures
- ☐ Best Ways to Contact Me

This will allow us to use our appointment time more efficiently. If you have any copies of prior psychiatric evaluation reports, reports of psychological testing, or any other documentation of prior mental health evaluation or treatment, please bring copies of these documents with you if we are meeting in person, or call us to discuss other arrangements.

I schedule the initial consultation when it seems likely that my training, experience and skills are appropriate to provide any ongoing treatment that is indicated, based on the concerns you described when you scheduled the consultation. However, in some cases I may recommend that a different clinician or specialist would be better qualified to provide whatever further treatment is indicated.

Included in this document package is a handout that describes my practice procedures (e.g., billing, how to reach me in an emergency, etc.). Please review that prior to our meeting. If you need to cancel or reschedule your first appointment, call to let me know as far in advance as possible, but at least 48 hours prior to the scheduled appointment. If an initial appointment is cancelled with insufficient advance notice or missed without notification, we will need to discuss rescheduling on the telephone.

A description of my privacy policies can also be accessed on my website (Resources/Forms). Please call the office if you have any other questions.

Steven E. Locke

PATIENT REGISTRATION FORM

REGISTRATION DATE M D Y

☐ UPDATED REGISTRATION

PRACTICE NAME (OFFICE USE ONLY) | PRACTICE NO. | PATIENT NO. | CROSS REFERENCE ID NO.

PERSONAL INFORMATION

PATIENT NAME (LAST) (FIRST) (MI)

MAIDEN NAME (IF APPLICABLE)/OPTIONAL STREET ADDRESS

STREET ADDRESS (MAILING)

CITY | STATE | ZIP CODE

HOME PHONE (INCLUDE AREA CODE) | BUSINESS PHONE (INCLUDE AREA CODE)

SEX M F | DATE OF BIRTH M D Y | AGE | MARITAL STATUS M S D W | SOCIAL SECURITY NUMBER

GUARANTOR NAME (PERSON TO BILL IF OTHER THAN PATIENT)

STREET ADDRESS

CITY | STATE | ZIP CODE

HOME PHONE (INCLUDE AREA CODE) | BUSINESS PHONE (INCLUDE AREA CODE)

PRIMARY CARE PHYSICIAN (LAST, FIRST, MI) | PROVIDER #

STREET ADDRESS

CITY | STATE | ZIP CODE

OCCUPATION

EMPLOYER NAME

STREET ADDRESS

CITY | STATE | ZIP CODE

CLOSEST RELATIVE | RELATIONSHIP

STREET ADDRESS

CITY | STATE | ZIP CODE

HOME PHONE (INCLUDE AREA CODE) | BUSINESS PHONE (INCLUDE AREA CODE)

REFERRING PHYSICIAN (LAST, FIRST, MI) | **UPIN #/PROVIDER#**

STREET ADDRESS

CITY | STATE | ZIP CODE

PHONE (INCLUDE AREA CODE)

HEALTH INSURANCE

HEALTH INSURANCE	SUBSCRIBER INFORMATION	IDENTIFICATION NO.	COPY OF INS. ID CARD ATTCHD
PRIMARY COMPANY NAME ADDRESS	SUBSCRIBER NAME PATIENT'S RELATIONSHIP TO SUBSCRIBER (CIRCLE ONE) SELF 1 | SPOUSE 2 | CHILD 3 | OTHER 4	CERTIFICATE NO. GROUP NO. / NAME	☐
SECONDARY COMPANY NAME ADDRESS	SUBSCRIBER NAME PATIENT'S RELATIONSHIP TO SUBSCRIBER (CIRCLE ONE) SELF 1 | SPOUSE 2 | CHILD 3 | OTHER 4	CERTIFICATE NO. GROUP NO. / NAME	☐
OTHER INS. COMPANY NAME ADDRESS	SUBSCRIBER NAME PATIENT'S RELATIONSHIP TO SUBSCRIBER (CIRCLE ONE) SELF 1 | SPOUSE 2 | CHILD 3 | OTHER 4	CERTIFICATE NO. GROUP NO. / NAME	☐

INJURY

☐ WORKERS' COMP ☐ AUTO ACCIDENT ☐ OTHER

CLAIM NO.

INSURANCE COMPANY NAME | FILE NO.

ADDRESS | DATE OF INJURY

EXTENDED AUTHORIZATION AND CONSENT

I request that payment under the medical insurance program be made directly to the above named provider on any unpaid bills for services provided on or after the date indicated below. I authorize any holder of medical or other information about me to release to the Social Security Administration, its intermediaries *or* carriers of insurance companies, any information needed for this or a related Medicare *or* insurance claim. I understand that I am financially responsible for all charges not covered by my insurance, including those resulting from my failure to obtain the necessary referral and/or other authorizations from my primary care and/or referring physician when required. I permit a copy of this authorization to be used in place of the original.

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE X

DATE / /

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FINANCIAL AGREEMENT

PATIENT'S NAME		DOB	

Insurance coverage varies widely and it is your responsibility to understand the terms and limitations of your policy. Co-payments and payments to meet insurance deductibles are your responsibility. In certain situations there may be perceived advantages to not using your insurance to pay for your sessions – you may elect to self-pay by credit card, cash or personal check. Clients paying on a self-pay basis are expected to pay in full at time of service unless a payment plan has been arranged in advance. My practice manager, Susan Brown, will send you an invoice by mail where you will have the option to pay by credit card, online secure invoice (Stripe) or check.

Sessions are by appointment only. If there are any cancellations or changes that you need to make to your scheduled appointment, at least a 24-hour advance notice is required. Please note that if the 24-hour policy is not honored, you will be charged for the time reserved for you at my customary fee. Insurance companies cannot be billed for missed appointments.

By signing below, you agree to assume full responsibility for, and agree to pay on demand, all costs, charges and expenses of my services provided to you. No extensions granted to you, fee waivers or reductions and no delays or lack of diligence in enforcing any rights against you, shall in any way release you from your obligations or act as a waiver of any subsequent failure to make payment. *If you are experiencing hardship that is interfering with your current ability to pay your bill or possibly become a problem in the future, please contact me as soon as possible so that we can discuss your circumstances and possibly make alternative arrangements.*

I have read this Financial Agreement and understand that I am agreeing to be personally responsible for the charges on my patient account. I understand and agree that payment in full is due at the time services are rendered.

I am providing my credit card information below to guarantee payment for services provided or time reserved, or in the event that there is a delinquent payment for services provided. Delinquent payments beyond 30 days will be assessed a fee of 1% per month service charge or, if necessary, the costs of collection.

VISA / MC / AMEX		EXP	/	CVV		ZIP	

Patient/authorized representative:

PRINT NAME		
EMAIL		
SIGNATURE		DATE

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ACKNOWLEDGMENT OF RECEIPT OF PRIVACY PRACTICES

With my signature below, I acknowledge receipt of the *Notice of Privacy Practices* from the medical practice of Dr. Steven E. Locke.

SIGNATURE	
NAME	
	If personal representative, please provide patient's name and relationship to patient (e.g., parent, guardian, etc.)
DATE	

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PATIENT TELEHEALTH CONSENT FORM

I. INTRODUCTION

I understand that my continued medical care could be facilitated by using telehealth for my therapy. My provider has informed me of the benefits and risks of using telehealth as a method of health care delivery. As a result of this discussion, I have decided to use telehealth for my care. I have signed this form electronically at my first telehealth appointment after having been given an opportunity for my provider to answer any questions. I understand that a signed copy of this form will be placed in my medical record.

II. BENEFITS

- I understand that my provider believes that telehealth will benefit my care.
- I understand that under certain conditions, such as during an epidemic when public health authorities have recommended self-quarantine or social distancing, it may be safer to receive care at home rather than travel to a doctor's office or other clinical setting.
- I understand that telehealth doesn't replace the potential need for in-person appointments between me and my provider. This determination will be made by my provider.
- My provider has given me instructions on the proper use of telehealth and has answered all my questions to my satisfaction.

III. FEDERAL and STATE LAW

Federal law requires that health care providers protect the privacy and security of my personal health information.

- I understand that my provider has undertaken reasonable efforts to provide a system designed to protect the security and privacy of my personal health information using HIPAA-compliant protocols, including the selection of technology partners who are also governed by federal and state regulatory requirements regarding the protection and privacy of patient health information, at the provider's location.
- I understand that my provider must inform me of the location of provider rendering services and obtain the location of the patient receiving services.
- I understand that federal and state law is changing rapidly in response to the COVID-19 epidemic and that this provider will use technology that is allowable by state and federal law.

IV. RISKS

- I understand that my telehealth sessions help my provider care for me but may be different from in-person, face-to-face treatment. If the standard of care cannot be maintained using this method of healthcare delivery, my provider will notify me that this is the case and advise me to seek in-person care.
- I understand that there are risks and consequences from telehealth, including, but not limited to, disruptions or distortions of video and audio transmission due to technical difficulties. Deficiencies or

failures of the equipment could result in delay in medical evaluation or treatment and could affect the treatment session.
- There is potential for unauthorized interruptions by third parties.
- I understand that my insurance carrier may refuse to pay or reimburse for telemedicine, in which case I will be responsible for payment.

V. CONSENT

- I understand that I may withdraw my consent to continue treatment by telehealth at any time. However, any treatment received from my provider prior to receipt of my withdrawal of consent will not be affected.
- My withdrawal of consent and termination of telemedicine-based treatment will not affect my current or future treatment by my provider.
- I understand that I am responsible for providing equipment and internet or telephone access for telehealth.
- I understand that I am responsible for arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my telehealth appointments.
- No third parties shall be present or have access to a telemedicine session during its occurrence without my and my provider's written permission.
- I understand that it will be my responsibility to determine whether my insurance carrier will provide coverage for any treatment I receive, and I will be responsible for full payment in the event that the insurer denies coverage.
- I have had the opportunity to ask questions about the use of telemedicine including the risks and benefits and my provider has answered all of my questions to my satisfaction.

I have read and I understand the information provided above regarding my treatment by telehealth and have been given the opportunity to ask questions of my provider.

SIGNATURE OF PATIENT OR GUARDIAN	
NAME	
	If personal representative, please provide patient's name and relationship to patient (e.g., parent, guardian, etc.)
DATE	
SIGNATURE OF PROVIDER	
DATE	

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PATIENT EMAIL AND TEXT CONSENT FORM

PATIENT'S NAME		DOB	
EMAIL		CELL PH	

IF APPLICABLE:

GUARDIAN NAME		RELATIONSHIP	
GUARDIAN EMAIL			

I. RISK OF USING EMAIL AND TEXT

Transmitting patient information by email or text has a number of risks that patients should consider. These include, but are not limited to, the following:

- Email and text can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
- Email or text senders can easily misaddress an email or text.
- Backup copies of email or text may exist even after the sender or the recipient has deleted his or her copy.
- Employers and on-line services have a right to inspect email and texts transmitted through their systems.
- Email and texts can be intercepted, altered, forwarded, or used without authorization or detection.
- Email and texts can be used to introduce viruses into computer systems.

II. CONDITIONS FOR THE USE OF EMAIL AND TEXT

The Provider cannot guarantee but will use reasonable means to maintain security and confidentiality of email or text information sent and received. The Patient and Provider must consent to the following conditions:

- Email and text are not appropriate for urgent or emergency situations. The Provider cannot guarantee that any particular email or text will be read or responded to.
- Email and text must be concise. The Patient should schedule an appointment if the issue is too complex or sensitive to discuss via email or text.
- Email and text communications between patient and provider may be filed in the Patient's permanent medical record.
- The Patient's messages may also be delegated to another provider or staff member for response. Office staff may also receive and read or respond to patient messages.
- The Provider will not forward patient-identifiable emails or texts without the Patient's prior consent, except as authorized or required by law.
- The Patient should not use email or text for communication regarding sensitive medical information.
- It is the Patient's responsibility to follow up and/or schedule an appointment if warranted.

- **Recommended uses of patient-to-provider email or text should be limited to:**
  - Appointment requests
  - Prescription refills
  - Requests for information
  - Non-urgent health care questions
  - Updates to information or exchange of non-critical information such as laboratory values, immunizations, etc.

III. INSTRUCTIONS

To communicate by email or text, the Patient shall:

- Avoid use of his/her employer's computer.
- Put the Patient's name in the body of an email.
- Put the topic (e.g. medical question, billing question) in the subject line.
- Inform the Provider of changes in the Patient's email address or mobile phone number.
- Take precautions to preserve the confidentiality of email and text.
- Contact the Provider's office via conventional communication methods (phone, fax, etc.) if the patient does not receive a reply within a reasonable period of time.

IV. PATIENT ACKNOWLEDGMENT AND AGREEMENT

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of email and text between the Provider and me. I consent to the conditions and instructions outlined here, as well as any other instructions that the Provider may impose to communicate with me by email or text. I agree to use only the pre-designated email address and mobile number specified above. Any questions I may have had were answered.

☐ I authorize Steven Locke MD to contact me using the email address provided above (including my name, information regarding account balance, appointment information, and instructions for accessing the patient portal).

☐ I authorize Steven Locke MD to contact me using text messaging using the mobile number provided above (including my name, information regarding my account balance, and appointment information).

☐ I do not wish to be contacted by email.

☐ I do not wish to be contacted by text messaging.

SIGNATURE OF PATIENT OR GUARDIAN DATE

SIGNATURE OF PROVIDER DATE

Steven E. Locke, MD, DLFAPA

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CONSENT FOR USE OF MEDICATION

I understand that during my treatment by Dr. Locke, he may recommend medication as a treatment option when it has been found to be effective in treating patients with symptoms or conditions like mine. I have the right to accept or refuse medication. Medication has the potential for both risks and benefits. We have discussed the reasons using specific medications might help me and the known, associated risks. I understand that some medication-related risks are rare or even unknown, and I accept those risks following my discussion with Dr. Locke. I am making an informed choice to take the medication(s) he has suggested, according to the instructions provided.

Dr. Locke has reviewed the issues related to my use of the medication(s). I have had the opportunity to ask questions and he has answered them to my satisfaction. He has explained:

1. the reasons for taking the medication including which of my symptoms or conditions are being treated and how the medication might help;
2. the likelihood of improving with medication or the likelihood of not improving or worsening without the proposed medication, as well as the risks of stopping it too soon;
3. alternatives to treatment with medication, if such options are available;
4. my right to withdraw consent at any time by informing him during a phone call, in writing, or during an office visit;
5. the type, frequency and dosage (including the use of PRN or "as needed" medications), method or route (for example, by mouth or injection), and expected length of time of taking the medication(s);
6. the known common and serious side effects of these medications and possible side effects if taken longer than 3 months;
7. how he monitors for the possibility of adverse drug interactions or new adverse effects of drugs as they become known.

I understand that treatment is a partnership and that both the doctor and the patient have responsibilities in order for treatment to be helpful. With regard to my responsibilities, I agree to:

1. read the information that is attached to the medication when I get it from the pharmacy, and, if I have any questions or concerns, to contact Dr. Locke before starting the medication. Dr. Locke has provided his mobile phone number and told me to contact him any time;
2. read any additional patient education material provided or recommended to help me to better understand my condition and its treatment;
3. take my medication as instructed and to report promptly to Dr. Locke any new symptoms, side effects or adverse reactions;
4. not stop a medication without discussing it in advance with Dr. Locke, unless it is an emergency (e.g., an allergic reaction or serious side effect);
5. discuss with Dr. Locke any changes in dose or frequency of the prescribed medication;
6. inform Dr. Locke of any new medications that I am taking, either over-the-counter medications or nutrition supplements or herbal remedies or new medications prescribed by other clinicians;
7. notify Dr. Locke if another doctor recommends stopping a medication prescribed by Dr. Locke.

SIGNATURE OF PATIENT OR GUARDIAN	DATE
PATIENT PRINTED NAME	DATE OF BIRTH
	
SIGNATURE OF PROVIDER: STEVEN LOCKE, MD	DATE

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QUESTIONNAIRE FOR NEW PATIENTS

Please complete this questionnaire and mail it or bring the completed questionnaire with you when you come for your appointment. If you need additional space, please use the back of the page. **All of the information you provide on this questionnaire will be treated with complete confidentiality**. Please do not email this form.

Today's date _____

Your Name _____

DOB _____ Age _____

Home Ph _____ Work Ph _____

Cell Ph _____ Email _____

Street Address _____

City _____ State _____ ZIP _____

Primary Care Physician _____

Street Address _____

City _____ State _____ ZIP _____

Phone _____

Who referred you to me? _____

I. Please state the reason you are seeking consultation.

What is the problem (or problems) you would like help with?

When and how did the problem(s) begin?

What have you done so far to try to alleviate the problem(s)?

II. Substance Use

Do you smoke cigarettes? ..... ☐ Yes ☐ No
IF YES, how many cigarettes daily? _____ For how many years? _____
Are you frequently exposed to second-hand smoke at work or at home? ..... ☐ Yes ☐ No
Do you drink caffeinated beverages (coffee, tea, or caffeinated soft drinks)? ..... ☐ Yes ☐ No
IF YES, how many caffeinated drinks per day? _____
Do you drink alcohol? ..... ☐ Yes ☐ No
IF YES, how many drinks per week? _____
Have you or anyone close to you ever thought that you had a drinking problem? ..... ☐ Yes ☐ No
Have you ever felt you ought to cut down on your drinking? ..... ☐ Yes ☐ No
Have people ever annoyed you by criticizing your drinking? ..... ☐ Yes ☐ No
Have you ever felt bad or guilty about your drinking? ..... ☐ Yes ☐ No
Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover ? ..... ☐ Yes ☐ No
Have you used "recreational" drugs (marijuana, cocaine, speed, hallucinogens)? ..... ☐ Yes ☐ No
IF YES, which drugs?

Have you or anyone close to you ever thought that you had a drug problem? ..... ☐ Yes ☐ No
Have you ever abused or misused prescription drugs? ..... ☐ Yes ☐ No
IF YES, provide details:

III. Psychiatric Treatment History

Have you ever been hospitalized for psychiatric treatment? ☐ Yes ☐ No
IF YES, please specify:
Dates of hospitalization: from _____ to _____ .
Name of hospital: _____
Reason for hospitalization: _____
Was the hospital treatment helpful? ☐ Yes ☐ No
Dates of hospitalization: from _____ to _____ .
Name of hospital: _____
Reason for hospitalization: _____
Was the hospital treatment helpful? ☐ Yes ☐ No

Are you currently seeing a psychiatrist? ☐ Yes ☐ No

IF YES, please specify:

Name of psychiatrist: _____ Seeing since _____

What town is s/he in? _____ Telephone number _____

Has this treatment been helpful? ☐ Yes ☐ No

Are you currently seeing a therapist or counselor? ☐ Yes ☐ No

IF YES, please specify:

Name of therapist: _____ Seeing since _____

What town is therapist in? _____ Telephone number _____

Has this therapy been helpful? ☐ Yes ☐ No

Are you **currently** taking any medication for treatment of psychiatric or emotional problems?

☐ Yes ☐ No

IF YES, please specify:

Name of medication	Dose and frequency	Taken when? (dates)	Benefits and/or side effects

Have you seen other psychiatrists, therapists or counselors in the past? ☐ Yes ☐ No

IF YES, please specify:

	Dates of Treatment		**Was treatment helpful?**		
Name of Clinician	From	To	Yes	No	Not sure
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐

Have you taken medications **in the past** for treatment of psychiatric or emotional problems?

☐ Yes ☐ No. IF YES, please specify:

Name of medication	Dose and frequency	Taken when? (dates)	Benefits and/or side effects

IV. Medical History

Overall, would you say your physical health is:

☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

Have you suffered from any of the following medical problems? (check all that apply)

- ☐ allergic reactions to medications
- ☐ high blood pressure
- ☐ food allergies
- ☐ hepatitis
- ☐ environmental allergies
- ☐ chronic pain
- ☐ asthma
- ☐ HIV/AIDS
- ☐ Cancer
- ☐ cataract
- ☐ diabetes
- ☐ glaucoma
- ☐ head injuries
- ☐ severe or recurrent headaches
- ☐ hearing impairment
- ☐ heart disease
- ☐ loss of consciousness
- ☐ recurrent gastrointestinal illness (nausea, vomiting, constipation, or diarrhea)
- ☐ hospitalization for medical illness in the last 5 years
- ☐ other medical problems (describe)hormonal problems
- ☐ kidney problems
- ☐ liver problems
- ☐ prostate problems
- ☐ seizures
- ☐ stroke
- ☐ surgery
- ☐ sexually-transmitted disease
- ☐ thyroid condition
- ☐ ulcers

IF YES to any of above, please provide details:

Have you noticed any of the following symptoms or problems **in the last six months**?

(Please check all that apply)

- ☐ fevers
- ☐ fatigue
- ☐ weight loss
- ☐ changes in your vision
- ☐ double vision
- ☐ eye pain or irritation
- ☐ hearing loss
- ☐ ringing in your ears
- ☐ ear pain
- ☐ sore throat
- ☐ nose bleeds
- ☐ runny nose
- ☐ sores in your mouth
- ☐ shortness of breath
- ☐ persistent cough
- ☐ wheezing
- ☐ chest pain
- ☐ rapid heart beat or palpitations
- ☐ swelling of legs or ankles
- ☐ nausea or vomiting
- ☐ diarrhea
- ☐ constipation
- ☐ abdominal pain
- ☐ blood in your urine
- ☐ painful urination
- ☐ difficulty passing urine
- ☐ sexual problems
- ☐ decreased interest in sex
- ☐ joint pain or swelling
- ☐ aches or pains in your arms or legs
- ☐ back pain
- ☐ breast swelling, masses, or discharge
- ☐ skin rashes or sores
- ☐ headaches
- ☐ dizziness, light-headedness, or vertigo
- ☐ numbness or tingling
- ☐ tremors
- ☐ problems with balance or coordination
- ☐ changes in menses
- ☐ hair loss
- ☐
- ☐
- ☐
- ☐
- ☐
- ☐
- ☐
- ☐
- ☐

IF YES to any of above, please provide details:

Are you concerned about the quality of your sleep? ..... ☐ Yes ☐ No

IF YES:

Trouble falling asleep? ..... ☐ Yes ☐ No

Frequent waking during the night? ..... ☐ Yes ☐ No

Wake up early in the morning and can't fall back to sleep? ..... ☐ Yes ☐ No

Don't feel rested in the morning? ..... ☐ Yes ☐ No

On average, how many hours of sleep do you get each night? _____

Do you frequently feel fatigued, exhausted, or sleepy during the day?..... ☐ Yes ☐ No

Has your weight changed significantly in the last year? ☐ Yes ☐ No

IF YES Weight gain? How much _____ lbs. Weight loss? How much _____ lbs.

Date of your last physical examination: _____ By whom: _____

Were laboratory or imaging studies done? (IF YES, please obtain and provide the results or reports.)

Are you currently taking any medication other than the psychiatric medications listed above (include prescription medications, birth control pills, and over-the-counter medicines, such as cold or allergy preparations)?

☐ Yes ☐ No IF YES, please specify below. Use additional page if needed.

Name of medication	Dose and frequency	Taken when? (dates)	Why taking this medication?

Are you currently sexually active? ☐ Yes ☐ No

How would you describe your sexual orientation?

☐ Heterosexual ☐Gay/Lesbian ☐ Bisexual

Females Only

IF you are sexually active with a man, are you using any form of birth control? ☐ Yes ☐ No

IF YES, what form of birth control do you use?

Date of your last gynecological examination _____

Do you have any problems related to your menstrual periods, such as irregular periods, prolonged or especially painful periods, or excessive bleeding? ☐ Yes ☐ No

IF YES, please describe:

Do your symptoms (anxiety, depression, other psychiatric symptoms) vary according to any pattern during the course of your menstrual cycle? For example, do you become more depressed, anxious, or irritable before your period? ☐ Yes ☐ No

IF YES, please describe:

Have you ever been pregnant? ☐ Yes ☐ No

IF YES, please specify:	Number	How old were you?
Live births		
Miscarriages		
Abortions		

Have you ever had a serious depression after the birth of a child? ☐ Yes ☐ No

Are you currently trying to become pregnant or do you plan to try to become pregnant in the near future? ☐ Yes ☐ No

Are you currently breast-feeding? ☐ Yes ☐ No

Have you gone through the menopause? ☐ Yes ☐ No. IF YES, at what age? _____

Males only

If you are sexually active, do you use a condom? ☐ Yes ☐ No

Do you have any problems with sexual function (erections, ejaculation)? ☐ Yes ☐ No

V. Personal History

Family Background

	First Name	Current age or age at death	If not living, your age when he or she died	Occupation	☑ if living with you	If alive and **not** living with you, where does he or she live now?
Spouse					☐	
Children					☐	
					☐	
					☐	
					☐	
Father					☐	
Mother					☐	
Brothers & Sisters					☐	
					☐	
					☐	
					☐	
					☐	

Others living in your household

Name	Relationship to you	Age

Marital status

☐	Married	How long	☐ Separated	How long
☐	Life partner	How long	☐ Separated	How long
☐	Divorced	How long	☐ Widowed	How long
☐	Never married			

Have you been married previously? ☐ Yes ☐ No. IF YES, please list dates of previous marriages:

If you are currently married or living with a partner, are you now or have you in the past experienced significant conflicts in your relationship? ☐ Yes ☐ No

IF YES, please describe:

Family stressors

Do any family/household members currently suffer from significant physical health problems?

☐ Yes ☐ No. IF YES, please describe:

Do any family/household members currently suffer from significant mental/emotional health problems?

☐ Yes ☐ No. IF YES, please describe:

Are there any other significant stresses currently affecting your family life (e.g., financial concerns, health problems, extended family concerns or conflicts, job problems, etc.)?

☐ Yes ☐ No. IF YES, please describe:

Safety

Have you ever been exposed to violence in your living situation (as a child or as an adult)?

☐ Yes ☐ No. IF YES, please describe:

Do you feel safe in your current living situation?

☐ Yes ☐ No. IF NO, please describe:

Do you have access to firearms?

☐ Yes ☐ No. IF YES, please describe:

Do you use the following personal safety equipment:

- ☐ seatbelts
- ☐ bicycle helmet
- ☐ ski helmet
- ☐ nonslip surface or mat in bathtub
- ☐ working smoke detectors in home
- ☐ eye and/or ear protection

Education

Your educational attainment (check highest level obtained):

- ☐ 8th grade or less
- ☐ some high school
- ☐ high school graduate or equivalency (GED)
- ☐ some college or associate degree
- ☐ college graduate
- ☐ advanced college degree

Occupation

Your occupation _____

Work hours per week (approximate): _____

How many vacation days do you take per year? _____

When was your most recent vacation? _____

How long have you been in your current position? _____

How satisfied are you with your work or job?

☐ Very satisfied ☐ Satisfied ☐ Dissatisfied ☐ Very dissatisfied

Religion

When you were a child, what was your parents' religion?

Father _____ Mother _____

What is your religion? _____

How important are your religious or spiritual beliefs to you:

☐ Very important ☐ Important ☐ Somewhat important ☐ Unimportant

Is there someone in your life whom you can turn to for help or support? ☐ Yes ☐ No

If YES: how satisfied are you with the support available to you?

☐ Very satisfied ☐ Satisfied ☐ Dissatisfied ☐ Very dissatisfied

VI. Family History:

Have any of your biological relatives had ANY of the following problems?

	Father	Mother	Siblings	Your children	Other family
Depression					
Anxiety or nervousness					
Panic attacks or panic disorder					
Phobias (claustrophobia, fear of flying, etc.)					
OCD (obsessive-compulsive disorder)					
Alcohol abuse					
Drug abuse					
Schizophrenia					
Bipolar disorder (manic depressive)					
Obsessive-compulsive disorder					
Learning difficulties or ADHD as child					
Mental retardation					
Hospitalized for psychiatric problem					
Other psychiatric problem					
Suicide					
Violence					
Dementia (or Alzheimer's disease)					
Cancer					
Diabetes					
Heart disease					
Stroke					
Neurological disease (e.g., multiple sclerosis)					
Thyroid Disease					
Other familial medical illnesses					
Unknown					

VII. Recent stress

Please indicate with a ✔ the following:

In the last MONTH…	Never	Almost never	Sometimes	Fairly often	Very often
How often have you felt that you were unable to control the important things in your life?					
How often have you felt confident about your ability to handle your personal problems?					
How often have you felt that things were going your way?					
How often have you felt difficulties were piling up so high that you could not overcome them?					

VIII. Please indicate how much your problems have been interfering with your daily life.

Circle one number **above each line**.

1. Because of my problems, my **WORK** is impaired:

0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Not at all	Mildly		Moderately			Markedly		Very Severely (cannot work)		

2. Because of my problems, my **SOCIAL LIFE / LEISURE** is impaired:

0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Not at all	Mildly		Moderately			Markedly		Very Severely (No social life)		

3. Because of my problems, my **FAMILY LIFE AND ABILITY TO CARRY OUT HOME RESPONSIBILITIES** are impaired

0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Not at all	Mildly		Moderately			Markedly			Very Severely	

IX. Patient Health Questionnaire (PHQ)

1. During the last **4 weeks**, how much have you been bothered by any of the following problems? **(Use ✓ to indicate your answer)**

Problem	Not bothered (0)	Bothered a little (1)	Bothered a lot (2)	
Stomach pain				
Back pain				
Pain in your arms, legs, or joints (knees, hips, etc.)				
Menstrual cramps or other problems with your periods				
Pain or problems during sexual intercourse				
Headaches				
Chest pain				
Dizziness				
Fainting spells				
Feeling your heart pound or race				
Shortness of breath				
Constipation, loose bowels, or diarrhea				
Nausea, gas, or indigestion				
PLEASE ADD UP YOUR SCORE				

2. Over the last **2 weeks**, how often have you been bothered by any of the following problems? **(Use ✓ to indicate your answer)**

Problem	Not at all (0)	Some of the days (1)	More than half the days (2)	Nearly every day (3)	
Little interest or pleasure in doing things					
Feeling down, depressed, or hopeless					
Trouble falling or staying asleep, or sleeping too much					
Feeling tired or having little energy					
Poor appetite or overeating					
Feeling bad about yourself — or that you are a failure or have let yourself or your family down					
Trouble concentrating on things, such as reading the newspaper or watching television					
Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual					
Thoughts that you would be better off dead or of hurting yourself in some way					
PLEASE ADD UP YOUR SCORE					

3. Questions about anxiety

a. In the **last 4 weeks**, have you had an anxiety attack – suddenly feeling fear or panic? ☐ Yes ☐ No
(If you checked "NO", go to question #5.)

b. Has this ever happened before? ☐ Yes ☐ No

c. Do some of these attacks come suddenly out of the blue –– that is, in situations where you don't expect to be nervous or uncomfortable? ☐ Yes ☐ No

d. Do these attacks bother you a lot or are you worried about having another attack?
☐ Yes ☐ No

4. Think about your last bad anxiety attack.

a. Were you short of breath? ..... ☐ Yes ☐ No

b. Did your heart race, pound, or skip? ..... ☐ Yes ☐ No

c. Did you have chest pain or pressure? ..... ☐ Yes ☐ No

d. Did you sweat? ..... ☐ Yes ☐ No

e. Did you feel as if you were choking? ..... ☐ Yes ☐ No

f. Did you have hot flashes or chills? ..... ☐ Yes ☐ No

g. Did you have nausea or an upset stomach, or the feeling that you were going to have diarrhea? ..... ☐ Yes ☐ No

h. Did you feel dizzy, unsteady, or faint? ..... ☐ Yes ☐ No

i. Did you have tingling or numbness in parts of your body? ..... ☐ Yes ☐ No

j. Did you tremble or shake? ..... ☐ Yes ☐ No

k. Were you afraid you were dying? ..... ☐ Yes ☐ No

5. Over the **last 2 weeks**, how often have you been bothered by the following problems? **(Use ✓ to indicate your answer)**

Problem	Not at all (0)	Some of the days (1)	More than half the days (2)	Nearly every day (3)	
Feeling nervous, anxious or on edge					
Not being able to stop or control worrying					
Worrying too much about different things					
Trouble relaxing					
Being so restless that it is hard to sit still					
Becoming easily annoyed or irritable					
Feeling afraid as if something awful might happen					
PLEASE ADD UP YOUR SCORE					

6. Questions about eating:

a. Do you often feel that you can't control what or how much you eat? ..... ☐ Yes ☐ No

b. Do you often eat, within any 2-hour period, what most people would regard as an unusually large amount of food? ..... ☐ Yes ☐ No

c. Has this been as often as twice a week for the last 3 months? ..... ☐ Yes ☐ No

7. In the last 3 months have you often done any of the following in order to avoid gaining weight?

a. Made yourself vomit? ..... ☐ Yes ☐ No

b. Used laxatives to try to lose weight? ..... ☐ Yes ☐ No

c. Fasted—not eaten anything at all for at least 24 hours? ..... ☐ Yes ☐ No

d. Exercised for more than an hour specifically to avoid gaining weight after binge eating? ..... ☐ Yes ☐ No

e. Have you ever tried to lose weight because you thought you were fat even when others thought you were too thin? ..... ☐ Yes ☐ No

X. Have you served in the US Armed Forces

☐ Yes ☐ No

IF YES, what type of discharge?

XI. Other

Is there anything else that you think I should know about you?

Thank you for the time and effort it took to complete this questionnaire.

How much time did it take you to complete this questionnaire? _____ minutes

How useful do you think providing this information in this manner will be in your care?

☐ Very useful ☐ Useful ☐ Somewhat useful ☐ Not useful

Steven E. Locke, MD

10 Deer Run, Wayland, MA 01778

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED, DISCLOSED AND SAFEGUARDED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Who is Subject to This Notice

The medical practice of Steven E. Locke, M.D.

II. Our Responsibility

The confidentiality of your personal health information is very important to us. Your health information includes records that we create and obtain when we provide you care, such as a record of your symptoms, examination and test results, diagnoses, treatments and referrals for further care. It also includes bills, insurance claims, or other payment information that we maintain related to your care.

This Notice describes how we handle your health information and your rights regarding this information. Generally speaking, we are required to:

- Maintain the privacy of your health information as required by law;
- Provide you with this Notice of our duties and privacy practices regarding the health information about you that we collect and maintain;
- Follow the terms of our Notice currently in effect.

III. Contact Information

After reviewing this Notice, if you need further information or want to contact us for any reason regarding the handling of your health information, please direct any communications to:

Steven E. Locke, M.D.
Ten Deer Run, Wayland, MA 01778
(508) 343-0001

IV. Uses and Disclosures of Information

Under federal and state law, we are permitted to use and disclose personal health information without authorization for treatment, payment, and health care operations. However, it is my practice to seek your express consent before I make certain disclosures of your personal health information. An exception to this is that when I am collaborating in your health care with other clinicians who are treating you, we will share health information with each other, as necessary, to carry out treatment. If you have concerns about my sharing your personal health information with other clinicians, please notify me in writing as to any restrictions on my ability to share your medical information with them.

Example of using or disclosing health information for treatment:

- A nurse takes your pulse and blood pressure, records it in the medical record, and informs your doctor of the results.

Example of using or disclosing health information for payment:

- We submit a bill to your health insurer to receive payment for your care; the insurer asks for health information (for example, your diagnosis and what care we provided) in order to pay us. In such situations, we will disclose only the minimum amount of information necessary for this purpose.

Example of using or disclosing health information for health care operations:

- In the course of providing treatment to patients, we perform certain important functions such as quality assessment, training programs, credentialing, medical review, etc. In performing such functions, we may rely on certain business associates to assist us. We will share with our business associates only the minimum amount of personal health information necessary for them to assist us.

V. Other Uses and Disclosures

In addition to uses and disclosures related to treatment, payment, and health care operations, we may also use and disclose your personal information without authorization for the following additional purposes:

Abuse, Neglect, or Domestic Violence

- As required or permitted by law, we may disclose health information about you to a state or federal agency to report suspected abuse, neglect, or domestic violence. If such a report is optional, we will use our professional judgment in deciding whether or not to make such a report. If feasible, we will inform you promptly that we have made such a disclosure.

Appointment Reminders and Other Health Services

- We may use or disclose your health information to remind you about appointments or to inform you about treatment alternatives or other health-related benefits and services that may be of interest to you, such as case management or care coordination.

Business Associates

- We may share health information about you with business associates who are performing services on our behalf. For example, we may contract with a company to service and maintain our computer systems, or to do our billing. Our business associates are obligated to safeguard your health information. We will share with our business associates only the minimum amount of personal health information necessary for them to assist us.

Communicable Diseases

- To the extent authorized by law, we may disclose information to a person who may have been exposed to a communicable disease or who is otherwise at risk of spreading a disease or condition.

Communications with Family and Friends

- We may disclose information about you to persons who are involved in your care or payment for your care, such as family members, relatives, or close personal friends. Any such disclosure will be limited to information directly related to the person's involvement in your care.
- If you are available, we will provide you an opportunity to object before disclosing any such information. If you are unavailable because, for example, you are incapacitated or because of some other emergency circumstance, we will use our professional judgment to determine what is in your best interest regarding any such disclosure.

Coroners, Medical Examiners, and Funeral Directors

- We may disclose health information about you to a coroner or medical examiner, for example, to assist in the identification of a decedent or determining cause of death. We may also disclose health information to funeral directors to enable them to carry out their duties.

Disaster Relief

- We may disclose health information about you to government entities or private organizations (such as the Red Cross) to assist in disaster relief efforts.

- If you are available, we will provide you an opportunity to object before disclosing any such information. If you are unavailable because, for example, you are incapacitated, we will use our professional judgment to determine what is in your best interest and whether a disclosure may be necessary to ensure an adequate response to the emergency circumstances.

Food and Drug Administration (FDA)

- We may disclose health information about you to the FDA, or to an entity regulated by the FDA, in order, for example, to report an adverse event or a defect related to a drug or medical device.

Health Oversight

- We may disclose health information about you for oversight activities authorized by law or to an authorized health oversight agency to facilitate auditing, inspection, or investigation related to our provision of health care, or to the health care system.

Judicial or Administrative Proceedings

- We may disclose health information about you in the course of a judicial or administrative proceeding, in accordance with our legal obligations.

Law Enforcement

- We may disclose health information about you to a law enforcement official for certain law enforcement purposes. For example, we may report certain types of injuries as required by law, assist law enforcement to locate someone such as a fugitive or material witness, or make a report concerning a crime or suspected criminal conduct.

Minors

- If you are an unemancipated minor under Massachusetts law, there may be circumstances in which we disclose health information about you to a parent, guardian, or other person acting *in loco parentis*, in accordance with our legal and ethical responsibilities.

Notification

- We may notify a family member, your personal representative, or other person responsible for your care, of your location, general condition, or death.
- If you are available, we will provide you an opportunity to object before disclosing any such information. If you are unavailable because, for example, you are incapacitated or because of some other emergency circumstance, we will use our professional judgment to determine what is in your best interest regarding any such disclosure.

Parents

- If you are a parent of an unemancipated minor, and are acting as the minor's personal representative, we may disclose health information about your child to you under certain circumstances. For example, if we are legally required to obtain your consent as your child's personal representative in order for your child to receive care from us, we may disclose health information about your child to you.
- In some circumstances, we may not disclose health information about an unemancipated minor to you. For example, if your child is legally authorized to consent to treatment (without separate consent from you), consents to such treatment, and does not request that you be treated as his or her personal representative, we may not disclose health information about your child to you without your child's written authorization.

Personal Representative

- If you are an adult or emancipated minor, we may disclose health information about you to a personal representative authorized to act on your behalf in making decisions about your health care.

Public Health Activities

- As required or permitted by law, we may disclose health information about you to a public health authority, for example, to report disease, injury, or vital events such as death.

Public Safety

- Consistent with our legal and ethical obligations, we may disclose health information about you based on a good-faith determination that such disclosure is necessary to prevent a serious and imminent threat to the public or to identify or apprehend an individual sought by law enforcement.

Required By Law

- We may disclose health information about you as required by federal, state, or other applicable law.

Research

- We may disclose health information about you for research purposes in accordance with our legal obligations. For example, we may disclose health information without a written authorization if an Institutional Review Board (IRB) or authorized privacy board has reviewed the research project and determined that the information is necessary for the research and will be adequately safeguarded.

Specialized Government Functions

- We may disclose health information about you for certain specialized government functions, as authorized by law. Among these functions are the following: military command; determination of veterans' benefits; national security and intelligence activities; protection of the President and other officials; and the health, safety, and security of correctional institutions.

Workers' Compensation

- We may disclose health information about you for purposes related to workers' compensation, as required and authorized by law.

Any Other Use or Disclosure—Authorization Required

- Before using or disclosing your personal health information for any other purpose not identified above, we will obtain your written authorization. Unless action has already been taken in reliance on the authorization, you have a right to revoke such authorization by submitting your request in writing to us (see section III above for contact information).

VI. **Psychotherapy Notes**

It is not my practice to keep separate psychotherapy notes. Any information that you share with me may be recorded in your medical record and under certain circumstances, as described above, may be available to others, with, or under some rare circumstances, without, your permission. For this reason, I am careful not to record information that is not central to your medical care in the medical record. However, before sharing information with me, if you do not wish it to be included in your record, you must indicate that preference to me prior to the disclosure. In the event that I deem the information to be a necessary part of your medical record, I will inform you at the time of the disclosure.

VII. **Your Health Information Rights**

Under the law, you have certain rights regarding the health information that we collect and maintain about you. This includes the right to:

- Request that we restrict certain uses and disclosures of your health information; we are not, however, required to agree to a requested restriction.
- Request that we communicate with you by alternative means, such as making records available for pick-up, or mailing them to you at an alternative address, such as a P.O. Box. We will accommodate reasonable requests for such confidential communications.
- Request to review, or to receive a copy of, the health information about you that is maintained in our files and the files of our business associates. If we are unable to satisfy your request, we will tell you in writing the reason for the denial and your right, if any, to request a review of the decision.

- Request that we amend the health information about you that is maintained in our files and the files of our business associates. Your request must explain why you believe our records about you are incorrect, or otherwise require amendment. If we are unable to satisfy your request, we will tell you in writing the reason for the denial and tell you how you may contest the decision, including your right to submit a statement (of reasonable length) disagreeing with the decision. This statement will be added to your records.
- Request a list of our disclosures of your health information. This list, known as an "accounting" of disclosures, will not include certain disclosures, such as those made for treatment, payment, or health care operations. We will provide you the accounting free of charge; however, if you request more than one accounting in any 12-month period, we may impose a reasonable, cost-based fee for any subsequent request. Your request should indicate the period of time in which you are interested (for example, "from May 1, 2017 to June 1, 2017"). We will be unable to provide you an accounting for any disclosures made more than six years ago.
- Request a paper copy of this Notice.

In order to exercise any of your rights described above, you must submit your request in writing to me (see section III above for information). If you have questions about your rights, please speak with me, in person or by phone, or email, during normal office hours.

VIII. **To Request Information or File a Complaint**

If you believe your privacy rights have been violated, you may file a written complaint by mailing it or delivering it to our contact person (see section III above). You may complain to the Secretary of Health and Human Services (HHS) by writing to Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, D.C. 20201; by calling 1-(800) 368-1019; or by sending an email to OCRprivacy@hhs.gov. We cannot, and will not, make you waive your right to file a complaint as a condition of receiving care from us, or penalize you for filing a complaint

IX. **Revisions to this Notice**

We reserve the right to amend the terms of this Notice. If this Notice is revised, the amended terms shall apply to all health information that we maintain, including information about you collected or obtained before the effective date of the revised Notice. If the revisions reflect a material change to the use and disclosure of your information, your rights regarding such information, our legal duties, or other privacy practices described in the Notice, we will promptly distribute the revised Notice, make copies available to our patients and others, and post it on our website.

X. **Effective Date:**

27 April 2020.

Steven E. Locke, MD

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PRACTICE PROCEDURES

Practice procedures

The changing health care system has made the process of giving and receiving care more complicated. To minimize the intrusion of these administrative details into our office time, I am providing the following information to you in writing. After reading this, we can discuss any questions you may have. Please save this for future reference.

Appointments

My regular practice hours are limited to 8 a.m to 1 p.m., Monday through Thursday. We can arrange alternate appointment times for emergencies or other unusual situations should they arise.

Emergencies

Please call me whenever you have an urgent concern. **On your first visit, I will give you my mobile phone number**. If you miss me and your message is non-urgent, leave a message on my voice mail. I retrieve messages several times daily. Please leave a brief message about your concern and I will return the call as soon as possible. Be certain to leave your phone number and the date and time that you called as I sometimes retrieve my messages remotely. Always leave a voice message for me if you have not spoken with me directly. In addition, if it is urgent that you reach me be sure to indicate the degree of urgency in the message that you leave.

If you are unable to contact me and cannot wait for a return call, go directly to the emergency room at Beth Israel Deaconess Medical Center where there is always a psychiatrist on call who can assist you until I reach you. If you prefer, go to the emergency room of your local community hospital if it offers emergency psychiatric coverage. When you arrive at the emergency room, tell the staff that I am your doctor and ask them to contact me. If you are in a managed care insurance plan, your plan may require that you go to a specific hospital for emergency care. You should obtain this information from your insurer as soon as possible. When I am out of town, I cover my practice remotely by cellphone. If necessary, I arrange for a covering doctor whose contact information will be available from my voice mail.

E-mail: steven.locke@drstevenlocke.com

E-mail may be used for non-urgent communication. However, standard e-mail is not secure and therefore privacy cannot be assured. Do not include personal health information in an email. Never use e-mail for any urgent communication as there is no way to know whether I have received it.

Medication

Depending upon your clinical needs, we may consider the use of medication. We will work together to evaluate such a decision. I will help you to make an informed choice about this by providing you with information about the reasons for using medication, the potential benefits and risks, any available alternatives to medication, and my judgment and advice about the use of medication. Because all medications have potential side effects and risks, I will discuss these with you, answer your questions and address your concerns in order to provide you with the information you need to make an informed decision. Because of the possibility of drug-drug, drug-herb and drug-food interactions it is important that you disclose to me all medications that you use (both prescription and over the counter), as well as herbal remedies, vitamins, and nutritional supplements. Prior to starting any medication, I recommend that you always request and read the patient education material provided by the pharmacist. **Please call me whenever you have questions about the use of the medication or to report symptoms that might represent possible side effects. If you do not understand the patient information provided by the pharmacist, call me before starting the medication.**

Insurance

Often health insurance pays for a portion of your psychiatric treatment costs if the insurer determines that such care is medically necessary. Benefit plans vary widely so be sure to check with your insurer to determine the extent of your benefits. Most policies contain co-payment and/or deductible requirements for which you are responsible. The co-payment is due at the time of each appointment. It can be paid by check, cash or credit card in that order of preference. Whenever you receive an Explanation of Benefits (EOB) from your insurer advising you of a portion of the bill that you owe to me, please remit to me the balance for which you are responsible. Your insurance

carrier should notify you on the EOB if your benefits have been exhausted or the service is uncovered, in which case you are responsible for the bill. **Each policy year you have a deductible for which you are personally responsible. Be sure to check your deductible amount as you will be invoiced directly for your care until your deductible is satisfied and your insurance coverage begins.**

Insurance and Managed Care

I participate in specific insurance plans such as Blue Cross Blue Shield and Tufts Health Plan (but NOT Tufts Direct) and Always Health Partners (Partners Healthcare employees only). I am not a MassHealth provider or a Harvard Pilgrim provider. You may need a referral from your PCP or have to call the insurer's behavioral health toll-free number. Some insurance policies do have "out-of-network" benefits that may offset the cost of your care. You will need to contact your insurer to determine if you have this additional coverage benefit and arrange authorization.

Billing

If you use commercial insurance, you will usually have a co-pay due at the time of the visit. I prefer payment by personal check, but cash or credit cards are accepted. The remainder of the visit fee will be billed to your insurance. For some insurers, you are responsible for direct payment of your bill. For assistance with insurance reimbursement, please contact my practice manager, Susan Brown, at (978) 317-3303 or susan.brown@drstevenlocke.com. Statements are sent electronically or mailed each week. Payment is due within 14-days of receipt unless otherwise arranged. If you have a question about your bill, please call me or discuss it with me during the session. You may also contact Ms. Brown. Some services may not be covered benefits under your plan and your insurer will not pay for them. You will be notified when this occurs and the fee will be discussed. You are responsible for payment of any uncovered services.

Missed appointments and cancellations

The time of your appointment has been reserved for your use. Without advance notice, I cannot use it for someone else. For this reason, unless I have 24-hours advance notice, you will be charged for missed visits or late cancellations. Most insurance plans will reimburse for telemedicine visits and if you are unable to travel due to weather or illness we can still meet at the scheduled time using a secure, HIPAA-compliant videoconference session. Alternatively, if we can arrange a make-up visit within the same week, you will not be charged for the missed visit. With sufficient advance notice, I can usually fill cancelled hours. Insurance does not pay for missed appointments. You can sign a form to give me permission to send automatic appointment reminders by SMS or email.

Phone calls

If it is urgent that you reach me, it is best to call my mobile phone, which I will have given you on your first appointment. Please leave non-urgent messages for me at (508) 343-0001. There is no fee for occasional, brief telephone calls. If you are calling about medication, be sure to indicate the name of the name and address of the pharmacy you use. For any controlled substances, be sure to indicate the date you picked up your most recent prescription. medication, the strength, the instructions for use and the refill requests are only sent electronically to pharmacies.

Prescriptions

Please check your medicine bottles at each refill and before each office visit so you know when you will need your next prescription. To provide the best care, it is best to write prescription refills in the office where my records are available and potential drug interactions can be reviewed. This permits better supervision of medication use. In an emergency, I can send an electronic prescription (eRx) to your pharmacy. However, if you allow your medication to run out and require refill authorizations outside of scheduled office visits, there will be a $25 filling fee assessed. When leaving messages about medication always leave your full name, your phone number, the name and address of the pharmacy, the name of the medication(s), strength, and frequency. If your last prescription is about to run out or you notice that there are no refills left on the label, it is time to schedule a re-evaluation visit. In that situation, I may only prescribe a small amount of medication until I have been able to re-evaluate you in the office.

Confidentiality

The psychiatrist-patient relationship is a special one that requires assurance of privacy to foster self-disclosure. Therefore, your relationship with me is confidential and all communications from you to me are privileged, with the following exceptions: 1) communications with the referring physician or therapist; 2) communications to coordinate your care with other doctors or therapists; 3) communications with your insurer and its care managers if you choose to use insurance benefits; 4) communications with others to protect your safety or the safety of others; and 5) communications mandated by court order or legal proceedings. Because of the importance of these issues, I will discuss this matter with you in greater detail during our initial meetings.

Additional information is available on the practice website: **www.drstevenlocke.com**

There are a variety of resources available on the website, including handouts, forms, questionnaires, articles, and audio files for relaxation training and stress management exercises.

Steven E. Locke, MD

10 Deer Run, Wayland, MA 01778

(508) 343-0001 Phone | (508) 213-3776 Fax

steven.locke@drstevenlocke.com | www.drstevenlocke.com

Best Ways to Contact Me

Here are the best ways to reach me securely, protecting your privacy. Remember: I never disclose your personal health information to anyone without your written permission.

BEST: Telephone

Established patients who are in treatment with me will have been given my cell phone number. My cell phone voicemail is private; only I can access it. This is simple, familiar and the best for urgent or complex clinical information.

The office telephone number listed on the website (508) 343-0001 is a Google Voice number that is not secure but it forwards calls to my cellphone and also converts messages from speech to text so that if I cannot answer the call, I get sent a text message with the content of the message. **Do not leave personal health information on the voicemail for that number. This is fine for questions pertaining to billing or appointments.**

BEST: Snail Mail (USPS) or FedEx/UPS document delivery

HIPAA* considers it acceptable to send protected health information by mail or messenger services. The major limitation is that it is slow and that the sender may not know if I have received it or read it.

BEST Asynchronous communication: Patient Fusion portal (HIPAA secure)

My Electronic Health Records (EHR) system, Practice Fusion, has a patient-facing portal called Patient Fusion. If you are an established patient, a Patient Fusion account was created for you when I created your electronic record. You were sent an invitation to enroll in Patient Fusion and provided with a temporary password. If you need the invitation re-sent or a new password, let me know. I check Patient Fusion messages whenever I am using the EHR, but generally not on weekends or holidays. Do not send anything time-sensitive or urgent by Patient Fusion unless you alert me by phone or email that I have a message waiting to be picked up.

GOOD: FAX.

My FAX number is 508-213-3776.

Fax is fast, secure and HIPAA-compliant, but you have no way to know whether I have read what you sent to me by fax. Never send anything that is time-sensitive or urgent by FAX. My fax number is an eFax service but is HIPAA-compliant and only I can see faxes sent to me. It is best used for sending documents, medical records, test results, forms, etc.

CONVENIENT BUT NOT PRIVATE: Standard email

Familiar and easy to use, but not considered secure by HIPAA which prohibits doctors from sending or receiving protected health information via standard email. If you wish to be able to use standard email and accept the limitations, I have an informed consent form that you can download from my website that explains the advantages, disadvantages and limitations of standard email. If you think the convenience outweighs the risk we can use standard email if you sign the consent form, indicating that you accept the risk.

A good rule of thumb: never send me any personal information by standard email that would upset you if a hacker stole it, sold it, and it ended up published in the Boston Globe.

*THE **HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)** INCLUDES THE HIPAA PRIVACY RULE, WHICH IS COMPOSED OF NATIONAL REGULATIONS FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) IN HEALTHCARE TREATMENT, PAYMENT AND OPERATIONS BY COVERED ENTITIES.