AURA INTEGRA BEHAVIORAL HEALTH, PLLC
Augustine Mensah, MSN, BSPH, APRN, PMHNP-BC
NPI: 1982532511 • DEA: MM0798314 • APRN #APRN10004439
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PATIENT INTAKE PACKET

New Patient Registration & Consent Forms

Welcome to **Aura Integra Behavioral Health, PLLC**. Please complete all six forms before or at your first appointment. These documents are required by Massachusetts law, HIPAA, and 42 CFR Part 2 (federal substance use confidentiality law). All information is strictly confidential.

Instructions: Complete all forms in full. Return before your first appointment. Questions? Call/text **508-736-3588** or email **info@auraintegra.com**.

Patients seeking Medication-Assisted Treatment (Suboxone/MAT): Form 5 (42 CFR Part 2) is required before any substance use treatment information may be shared with any outside party.

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FORM 1 — PATIENT REGISTRATION

Date Completed: _____ Chart #: _____

PATIENT DEMOGRAPHICS

Legal Full Name: _____

Date of Birth: _____ **Gender Identity:** _____

Preferred Name: _____ **Pronouns:** _____

Home Address: _____

City: _____ **State / ZIP:** _____

Cell Phone: _____ **Home Phone:** _____

Email Address: _____

Race/Ethnicity (opt.): _____ **Preferred Language:** _____

Marital Status: ■ Single ■ Married ■ Divorced ■ Widowed ■ Partnered ■ Other

EMERGENCY CONTACT

Emergency Contact Name: _____ **Relationship:** _____

Emergency Contact Phone: _____ **May we leave voicemail? ■ Yes ■ No** _____

INSURANCE INFORMATION

Payment Type: ■ I have insurance (complete below) ■ Self-pay / No insurance

Primary Insurance Carrier: _____ **Member ID #:** _____

Group Number: _____ **Insurance Phone #:** _____

Policy Holder Name: _____ **Policy Holder DOB:** _____

Policy Holder Relationship: ■ Self ■ Spouse ■ Parent ■ Other

Secondary Insurance (if any): _____ **Member ID #:** _____

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REASON FOR VISIT

■ Psychiatric eval ■ Med management ■ Suboxone/MAT ■ ADHD evaluation ■ Anxiety/Depression ■ SUD/Addiction ■ Dual diagnosis ■ Other

Current concerns (brief): _____

Current medications (include OTC and supplements):

_____

_____

Known allergies:

_____

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FORM 2 — CONSENT TO TREATMENT

Psychiatric Mental Health Nurse Practitioner Services — 244 CMR 4.00

Nature of Services. I consent to receive psychiatric evaluation, medication management, and behavioral health services from Augustine Mensah, MSN, BSPH, APRN, PMHNP-BC, licensed in Massachusetts (APRN #APRN10004439), practicing at Aura Integra Behavioral Health, PLLC.

Medication Management. I understand medication may be recommended. I consent to receive prescriptions, which may include controlled substances. I agree to disclose all other medications and report any side effects promptly.

Controlled Substances Agreement. If controlled substances are prescribed, I agree to: use only as prescribed; not share or sell medications; consent to urine drug screening as clinically indicated; allow MassPAT checks at each visit.

Voluntary Participation. Treatment is voluntary. I may withdraw consent at any time with reasonable notice, understanding that abrupt discontinuation of some medications requires medical supervision.

Risks and Benefits. I have been or will be informed of the risks, benefits, and alternatives to proposed treatments and have had the opportunity to ask questions at any time.

No Guarantee of Outcome. Psychiatric treatment does not guarantee a specific result. Recovery and symptom improvement vary among individuals and may take time.

Emergencies. This practice does not provide 24/7 crisis services. In emergencies, call **911**, call/text **988** (Suicide & Crisis Lifeline), or go to the nearest emergency room.

Supervision & Collaboration. My provider collaborates with physicians as clinically appropriate under Massachusetts APRN regulations (244 CMR 4.00).

By signing below, I confirm I have read and agree to this Consent to Treatment.

Patient Signature: _____ **Date:** _____

Printed Name: _____ **Date of Birth:** _____

If signing on behalf of patient:

Guardian / Representative Signature: _____ **Relationship to Patient:** _____

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FORM 3 — TELEHEALTH INFORMED CONSENT

M.G.L. c. 175, §47BB — Massachusetts Telehealth Standards

What is Telehealth? Telehealth allows you to receive psychiatric care via secure, HIPAA-compliant video or audio technology. You will receive a secure link before each appointment.

Your Rights (M.G.L. c. 175 §47BB). You have the right to: (1) the same standard of care as in-person; (2) withdraw consent at any time; (3) full HIPAA confidentiality for all telehealth records.

Technology Requirements. You are responsible for a device with camera and microphone, stable internet, and a private location. If technology fails, your provider will attempt to continue by phone.

Limitations. Telehealth may not be appropriate for all clinical situations. Physical examination cannot be performed remotely. In-person evaluation may be required when clinically necessary.

Massachusetts Location Requirement. I confirm I will be physically located in Massachusetts during all telehealth visits. Services may only be provided to patients physically present in Massachusetts.

Confidentiality. All sessions are HIPAA-protected. I agree to attend from a private location and will inform my provider if anyone else is present.

No Recording. Recording of sessions by either party is prohibited without explicit written consent from both parties.

Insurance Coverage. Most insurers cover telehealth at the same rate as in-person. Copay and deductible obligations remain the same.

By signing below, I consent to receive telehealth services from Aura Integra Behavioral Health, PLLC.

Patient Signature:
_____ **Date:** _____

Printed Name:
_____ **Date of Birth:** _____

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FORM 4 — HIPAA NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

Federal law (45 CFR §164.520) requires that we provide you a Notice of Privacy Practices (NPP) describing how your Protected Health Information (PHI) may be used and disclosed. Our full NPP is available at **auraintegra.com/privacy.html** and upon request.

- Your information may be used for **Treatment** — to provide, coordinate, or manage your care.
- Your information may be used for **Payment** — to bill and receive payment from insurance.
- Your information may be used for **Healthcare Operations** — quality improvement and compliance.
- Certain uses require your **written authorization**, including marketing and sale of PHI.
- You have the right to **access, amend, and restrict** your records and receive an accounting of disclosures.
- You may file a complaint with the **U.S. Dept. of Health and Human Services** without retaliation.
- **Substance use treatment records** receive additional federal protections under 42 CFR Part 2 (see Form 5).

Full NPP: **auraintegra.com/privacy.html** and upon request.

By signing below, I acknowledge I have received or been offered the opportunity to review the Notice of Privacy Practices of Aura Integra Behavioral Health, PLLC.

Patient Signature: _____ **Date:** _____

Printed Name: _____ **Date of Birth:** _____

For Office Use — If Patient Refused or Unable to Sign:

Staff Initials: _____ **Date:** _____

Reason: _____

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FORM 5 — 42 CFR PART 2 CONFIDENTIALITY NOTICE

Federal Confidentiality of Substance Use Disorder Patient Records

IMPORTANT FEDERAL NOTICE: The confidentiality of alcohol and drug abuse patient records maintained by this practice is protected by federal law (42 CFR Part 2). This program may not disclose to any outside person that a patient attends this program, or any information identifying a patient as having a substance use disorder, except as authorized by specific written patient consent or as otherwise permitted by law.

WHAT 42 CFR PART 2 MEANS FOR YOU

• 42 CFR Part 2 provides **stronger protections than HIPAA** for substance use treatment records.

• Without your written authorization, we **cannot disclose** your diagnosis, treatment dates, medications, or any substance use information — not to other providers, family, insurers, employers, or law enforcement.

• This protection continues **after you are no longer a patient** and after your death.

• Federal criminal penalties apply to violations of 42 CFR Part 2.

• The authorization below is **entirely voluntary**. Your treatment is not conditioned on signing it.

OPTIONAL — AUTHORIZATION TO DISCLOSE SUBSTANCE USE RECORDS

Complete only if you wish to authorize a specific disclosure. You may revoke in writing at any time before action is taken.

I authorize Aura Integra Behavioral Health, PLLC to disclose to:

Name / Organization: _____

Address / Phone: _____

Information to disclose: ■ Diagnosis ■ Treatment dates ■ Medications prescribed ■ Progress notes ■ Discharge summary ■ All records

Purpose of disclosure: _____

Effective from: _____ **Expires on:** _____

I understand: (1) Records are protected under 42 CFR Part 2; (2) I may revoke in writing at any time; (3) The recipient may not re-disclose without my written consent; (4) My treatment is not conditioned on signing.

Patient Signature:
_____ **Date:** _____

Printed Name:
_____ **Date of Birth:** _____

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FORM 6 — FINANCIAL AGREEMENT

Fees, Billing, Insurance & No Surprises Act Acknowledgment

ESTIMATED SERVICE FEES

Service	CPT Code	Est. Self-Pay Rate
Initial Psychiatric Evaluation (60 min)	90792	$350 – $450
Medication Management Follow-Up (30 min)	99214	$200 – $275
Brief Follow-Up Visit (15–20 min)	99213	$150 – $200
MAT / Suboxone Management Visit	99213 / 99214	$150 – $250
Missed Appt / Late Cancel (< 24hr notice)	N/A	$75 (not billable to ins.)

Insurance Billing. We bill participating insurers on your behalf. You are responsible for copayments, deductibles, and coinsurance at time of service. Unpaid balances are due within 30 days.

Self-Pay. Payment is due at time of service. Please ask about sliding scale availability. A Good Faith Estimate is provided before each appointment per the No Surprises Act.

Insurance Verification. We verify your benefits before your appointment, but verification is not a guarantee of payment. You are ultimately responsible for any charges not covered by your plan.

Cancellation Policy. We require at least 24 hours notice to cancel or reschedule. Late cancellations and no-shows are charged $75, which is not billable to insurance. Chronic no-shows may result in discharge.

Returned Payments. A $35 fee applies to returned checks or failed payment methods.

NO SURPRISES ACT — GOOD FAITH ESTIMATE

Under the No Surprises Act (effective January 1, 2022), you have the right to a **Good Faith Estimate** of expected charges. If your bill exceeds the estimate by $400 or more, you may dispute it. Details: **auraintegra.com/good-faith-estimate.html**.

By signing below, I agree to the financial policies of Aura Integra Behavioral Health, PLLC and authorize insurance billing on my behalf.

Patient Signature: _____ **Date:** _____

Printed Name: _____ **Date of Birth:** _____

Optional — Credit Card Authorization for copay and balance auto-billing:

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Card Number (last 4 only): _____ **Expiration:** _____

■ I authorize Aura Integra Behavioral Health, PLLC to charge this card for copayments and outstanding balances.

Prepared per: Massachusetts 244 CMR 4.00 | HIPAA 45 CFR Parts 160 & 164 | 42 CFR Part 2 | M.G.L. c. 175 §47BB | No Surprises Act (2022). Last reviewed: August 2026.