ADVANCE THRU PSYCHOTHERAPY & FAMILY DEVELOPMENT, PA

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Location #1_____
Lawrenceville, NJ 08648

Location#2_____
West Orange, NJ 07052

I. INFORMED CONSENT

This form summarizes our business practices, to which you are agreeing. Please read carefully and ask any questions that may arise for you. Please initial the end of each section, indicating that you have read and understand that section. Once you are comfortable with what this agreement says, please sign the last page and return the form to me. Please feel free to request a copy for your records.

You have chosen to receive psychological and/or counseling services from the therapist whose name is checked above. Your choice has been voluntary and you understand that you may terminate these services at any time.

You understand that there is no assurance that you will feel better. Because psychotherapy is a cooperative effort between you and your psychologist, you will work with your therapist in a cooperative manner to resolve your difficulties.

You understand that during the course of your treatment, material may be discussed which will be upsetting in nature and this may be necessary to help you solve your problems.

You understand that records and information collected about you will be held and released in accordance with state laws regarding confidentiality and privilege of such records and information.

You understand that state and local laws require that a Psychologist report all cases of abuse or neglect of minors. We must also report sexual abuse of minors, **even if the minor has reached legal age, and is no longer a minor**. Psychologists must also report the existence of a clear danger to self or others.

You understand that the first session is known as a diagnostic evaluation. At this first session, we will discuss your presenting problems and complaints, history, previous therapy, medications, goals, etc. This thorough evaluation will permit your psychologist to create a treatment plan for you. Sometimes, the evaluation process takes more than one session. In all cases, the actual therapy sessions begin after the first session.

Patient Initial_____ Spouse Initial_____

II. Fees

(1) Initial Psychological Evaluation	$250
(2) Marital and/or Family Psychotherapy	$225
(3) Individual Psychotherapy (90834) (38 to 45 minutes face to face)	$200
(4) Individual Psychotherapy (90837) (53 to 60 minutes face to face)	$225
(5) Family Psychotherapy without patient present (90846)	$225

Fees are structured differently for holders of Medicare and/or insurance plans with which we participate. We honor the fee structure imposed by these plans. This will be discussed at the time that we establish your initial evaluation appointment. Sometimes there is confusion as to whether or not we actually participate with your plan. It is your job to contact the insurance company and gather the details. If you have received incorrect information from the insurer, it is your job to deal with the insurance company, to rectify any errors.

It is your responsibility to notify your therapist of any changes to health insurance, immediately.

If your insurance company demands that we issue a refund to them for services they previously paid, you agree to reimburse your psychologist for these fees (example, your health insurance terminated. The company paid the fees, but then realized their error and demands a refund.).

Patient Initial_____ Spouse Initial_____

III. More on Insurance

I understand that if I have a primary insurance plan, I must inform my psychologist of this information. I CANNOT just file claims through my spouse's insurance, if I have a plan through my job. Insurance companies are often able to determine that patients had a primary plan, often years after they paid for the services. When they make such a discovery, they return to us and demand repayment of all funds they wrongfully paid us, as in-network doctors, even if many years have passed. This results in the therapist (us) having to spend hours re-billing the primary insurance plan, and then trying to get the payments straightened out. If a secondary insurance plan conducts an audit and demands that my psychologist return all payments, I agree to reimburse my Doctor any fees the insurance takes back. In addition, I agree to reimburse my Doctor for the hours they spend trying to get the primary insurance to process the claims. The hourly cost for this service will be $50 per hour.

Patient Initial_____ **Spouse Initial**_____

IV. For Couples or Family Therapy

We have chosen to receive psychological and/or counseling services from the therapist whose name is checked above. Our choice are voluntary and we understand that we may terminate these services at any time. We are here to work on improving the emotional health of our family. Hence, we understand that our psychologist is committed to creating a safe environment where each of us feels free to share openly about our concerns and problems. We agree and understand that:

- It is not the job of the therapist to inform me of anything that my spouse might share with me.
- It is not the job of the therapist to take sides.
- In the event of any future legal actions, the therapist will not release any records.
- I understand that my therapist cannot take sides in any custody disputes.
- I understand that my therapist cannot make any child custody recommendations.
- I authorize my psychologist to speak with my spouse about relevant issues without my presence.

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We understand that there is no assurance that we will feel better or that our relationship will improve. Because psychotherapy is a cooperative effort between me and my psychologist, I will work with my therapist in a cooperative manner to resolve my difficulties.

Not applicable_____ **Patient Initial**_____ **Spouse Initial**_____

V. Payment

Payment is expected at the time services are rendered. We accept cash and checks. Please inform us if financial difficulties arise, so that we may work out plans that permit you to receive your therapy without excessive hardship. Occasionally, we will agree to have you pay your portion, while we wait for the insurance check. Many insurance companies do not honor assignment, which means they send the check to you, and not to us. In such cases, you agree that you will bring the insurance check to us promptly.

If you fail to honor the payment obligations that we agree upon, we have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court, which will require us to disclose otherwise confidential information. In most collection situations, the only information released is your name, nature of service provided, and the amount due. The costs of any legal actions will be added to your fees.

There is a $25 fee for bounced checks. Fees that are unpaid for 90 days may be turned over to a collection agency.

Patient Initial_____ **Spouse Initial**_____

VI. Cancellation/Missed Session Policy

Late cancellations or missed appointments are charged at the full fee. We realize that occasionally, illnesses or emergencies occur that are beyond your control. Hence, we allow one missed/late cancellation session per year. Otherwise, you must provide us with 48 hour cancellation notice, or you must pay the full fee for your session. Your insurance will not pay for any of these charges. .

Patient Initial_____ **Spouse Initial**_____

VII. Policies Regarding Phone and Email

We do not charge for time spent on the phone or email for the discussion of any procedural matters such as appointment schedules and issues regarding insurance companies.

We do charge for phone time spent on therapeutic issues, at the pro-rated rates listed above. Also, time spent communicating to others on your behalf, either by phone or in writing, is also charged accordingly.

We do not use E-mails as communication method for therapeutic issues, since emails are an unsecure form of communication.

Patient Initial_____ **Spouse Initial**_____

VIII. Insurance Billing

As a courtesy, we submit the insurance claims on your behalf, so that you receive reimbursement speedily. Claims are filed electronically, whenever possible.

Patient Initial_____ **Spouse Initial**_____

IX. Policies Regarding Insurance Companies

If I am planning to utilize my health insurance in order to make full or partial payment for psychological services, I understand that my insurance carrier may require certain information about me, my problems and my treatment be provided to them in the form of what are most commonly termed, "Out Patient Treatment Plans." I understand that these "Treatment Plans" may be required for what is termed "Utilization Review": A process whereby **my insurance carrier** determines whether additional psychological treatment is needed. I understand that the criteria most often used to make that determination is whether continued treatment is "Medically Necessitated." In some cases, insurance carriers require "Discharge Summaries" to be submitted by the treating Psychologist at the end of treatment.

I understand that in all instances the name checked above will explain the requirements of my particular insurance carrier in this regard and obtain separate authorization from me for the release of such treatment plans.

I understand that I may refuse to release such information to my insurance carrier. However, if I do refuse, I understand that my insurance carrier will in all likelihood refuse to make payment for additional services. I have the right to continue in treatment at my own expense.

I understand that in situations wherein my health insurance is of the kind known as an "Indemnity plan," there may also be need for such disclosure regarding of my treatment. If I choose to submit claims to my insurance carrier under this type of plan, or if I ask my Psychologist to submit such claims on my behalf, these claims will contain the necessary identifying information, the dates of service (e.g., individual psychotherapy, psychological testing), a fee for that service and a diagnostic code.

Patient Initial_____ **Spouse Initial**_____

X. Insurance Coordination of Benefits

You must check and inform us if you have more than one insurance policy. For example, you may have insurance coverage through your employer and your spouse. Sometimes, people ignore the insurance policy through their employer, and choose to gain coverage through their spouse's plan, because the financial coverage is better through the spouse's plan. **When you have TWO insurance policies, you cannot ignore your plan (through your employer) and choose to gain coverage through your spouse's policy**. The insurance companies are known to discover this, and they demand re-payment from us, if there was a primary policy in place. In such cases, we have to seek payment from you, for funds we must repay the insurance company. The correct procedure is to first file a claim through the primary insurance. Once that first claim is processed, we submit a claim to the secondary insurance plan.

Patient Initial_____ **Spouse Initial**_____

XI. Fees for Preparation of Disability/Court and all other Reports

I understand that there is a **minimum** charge of $25 for the preparation and submission of all reports that need to be faxed or mailed on my behalf to any disability company, employer or other external organization that requires the completion of forms on my behalf. Report preparation is charged on a pro-rated hourly rate of $100 per hour.

Patient Initial_____ **Spouse Initial**_____

XII. The Health Insurance Portability and Accountability Act (HIPPAA)

The Health Insurance Portability and Accountability Act (HIPPAA) is a Federal Law that has been implemented to protect health services consumers. The provisions of this law, as privacy, confidentiality, content disclosure and reporting, are congruent with state laws already carried out by this practice. These policies will continue and are also required by HIPPA. The privacy of your health information is protected by appropriate procedures and policies, such as coding for identity concealment, as well as following official rules of consent and disclosure. For example, your records are available to you but disclosed to others only with your permission, unless disclosure is required by law. Also, there is protection of your confidential information by keeping records in secure places. Cooperation will be extended in the appropriate processing and transmission of forms, such as the provision of correct procedural and diagnostic codes. Essentially, as in the past, you will receive the protection of the rules of privacy, security, and transaction as currently mandated by HIPPA.

Please sign this form to indicate that you have received the information in sections I through VIII and that you understand your rights as a recipient of health services under HIPPA guidelines.

Signature of Patient #1 _____

Signature of Parent, if Patient is a minor_____

Signature of patient #2 _____

Date _____