PSY
PSYCHOLOGICAL
SERVICES, P.C.

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WELCOME TO OUR PRACTICE – New Patient Packet

INFORMED CONSENT FOR PSYCHOLOGICAL SERVICES

INTRODUCTION

Thank you for scheduling an appointment with **PSYCHOLOGICAL SERVICES, P.C.** There are a few policies about our practice that would be helpful for you to know before you consent to treatment and/or evaluation. Please take a few minutes to review them. We will be happy to discuss any of these policies with you.

CONFIDENTIALITY

I understand and agree that my disclosures and communications are considered private and confidential except to the extent that I authorize a release of information, or under certain conditions listed below.

I understand that confidentiality of records of information collected about me will be held or released in accordance with state laws regarding confidentiality of such records and information. The privileged nature of these records shall survive my death and require a court order for their release, especially to a family member, household member, or friend, regardless if they are the executor of my estate.

I understand that confidential and privileged information may be released without my consent or authorization in the following circumstances (based upon New York State law):

(1) where abuse or harmful neglect of children, the elderly, or handicapped person is known or reasonably suspected; (2) if a person's life is in danger through intent of suicide or homicide; (3) consultation with professional colleagues while omitting names and identifying information; and if the client is a child, the therapist may speak with the parents with the child's knowledge without revealing any specific confidences. You may always request that information be discussed with another person (i.e., your physician) by requesting an 'INFORMATION RELEASE FORM" from your therapist.

By authorizing a release of information, I understand that I am waiving the confidential nature of the patient-therapist relationship.

I am aware that if I consent to an evaluation that is requested and/or paid for by a third party, the results of the evaluation will be sent to the third party.

APPOINTMENTS

Since appointment times are reserved for only the client for that time period, 24 hours notice must be given for cancellations or appointment changes. **Missed appointments cannot be billed to insurance companies so clients will be billed the full session fee for cancellations or missed visits with less than 24 hours notice.**

BILLING

You will be billed for all time spent with you or on your behalf. Sessions are calculated on an hourly basis. The therapy "hour" will usually consist of 50 minutes between therapist and client,

with the remaining time reserved for record keeping. Group therapy sessions are generally 90 minutes in length.

Fees will be charged at $300 per hour for clinical services including expert testimony, depositions, and review or preparations of documents.

Fees will be $185 per hour for initial diagnostic interview, $165 per hour for individual psychotherapy, and $180 for family psychotherapy. Psychological testing will be based upon the tests administered and the time spent in scoring and interpreting the test, in addition to time spent in the writing of the report on the test results.

Payment for services is due at the time of each session. While most insurance policies cover part of the fee, copays and deductibles are payable at the time of the session. **If, for any reason, an insurance company fails to pay, it is understood that the bill is the client's responsibility.**

PSYCHOLOGICAL SERVICES, P.C. may use a professional billing company to file paper or electronic insurance claims and to bill clients for unpaid balances. This consent authorizes **PSYCHOLOGICAL SERVICES, P.C.** to release information to a billing company, collection agency, or attorney for billing and collection purposes.

MANAGED CARE CONTRACTS

It is understood that **PSYCHOLOGICAL SERVICES, P.C.** has contracts with several managed care companies and preferred provider organizations, in which case the terms of those contracts may take precedence over those of this consent form. In the event that any of the terms of this consent form might conflict with any of **PSYCHOLOGICAL SERVICES'** contracts with managed care companies or preferred provider organizations, the terms of those managed care contracts will supersede.

STATEMENT OF UNDERSTANDING

I am aware that psychological treatment is not an exact science and I acknowledge that no guarantees have been made to me as to the results of treatment or assessment.

This consent will be considered valid for thirty (30) days after the date my account is paid in full, or for twelve (12) months following the date below, whichever date is later. I acknowledge that I voluntarily consent to the preceding conditions and that this authorization form is valid during any related claims.

I certify that I have read this form or that it has been read and explained to me in terms that I have understood. By signing this form, I understand and agree with the conditions of this form.

_____ _____

PATIENT SIGNATURE **DATE**

_____ _____

THERAPIST SIGNATURE **DATE**