Behavioral Health Solutions, PC
Outpatient Services Agreement

Confidentiality
All communications between a patient and psychologist/therapist are protected by law. ***Generally, it is our practice to consult with your/your child's physician regarding our work together, including a written progress note after each visit.*** Confidentiality will be strictly guarded. Written or verbal information regarding your treatment at this clinic is only released to individuals you identify with your written permission.

☐ I authorize BHS to release all treatment information to my primary care physician. _____ (Initial)

☐ I decline and do not wish for BHS to release treatment information to my primary care physician. _____ (Initial)

Please do not use Short Message Service (i.e., text messaging) or instant messaging on Social Networking sites such as Twitter, Facebook, or LinkedIn to contact me. These sites are not secure. Do not use Wall postings, @replies, or other means of engaging with me in public online if we have an already established client/therapist relationship.

There are a few exceptions to confidentiality. We may be required to release or disclose information regarding our work with you/your child in situations involving danger or imminent risk of harm to the patient or others, child abuse, or in legal proceedings where emotional condition is an important element (e.g., child custody hearings). These situations are rare; however, we will make every effort to discuss the matter with you before disclosing such information. In addition, there may be times with the psychologist/therapist may consult with other professionals about your case. If so, the psychologist/therapist will make every effort to avoid revealing any identifying information about your family. The consultant is also bound to confidentiality. These consultants will not be discussed with you unless the psychologist/therapist believes it is important in your work together. Behavioral Health Solutions participates in teaching therapy students and trainees. Details of the training and supervision are noted below.

In case of emergency, please call 911 or proceed to the nearest emergency room. Please speak with your therapist for specific instructions.

Training and Supervision
Behavioral Health Solutions clinicians are affiliated with Munroe-Meyer Institute (MMI) which is a training facility dedicated to developing leadership skills in the delivery of pediatric services. As part of this training affiliation therapy students and trainees may participate as observers, co-therapists, and in some cases lead therapists, though they will always be supervised directly by the Behavioral Health Clinician and a licensed psychologist at MMI.

Treatment Approach
BHS employs an active, practical, brief, and research-supported approach to treatment. We typically conduct an intake evaluation and provide initial recommendations during the first one or two sessions. If we agree to additional sessions, regular attendance is very important. If you are unable, for any reason, to attend regularly we may choose to discontinue treatment. If treatment is ended prematurely, for any reason, we will work with you to find treatment alternatives as needed.

Fees
The patient (or the patient's parent, legal guardian, or authorized representative) retains responsibility for payments of all fees, whether or not they are covered by insurance. The following rates are charged for services provided by Licensed Psychologists (LPs). The initial intake evaluation which usually includes the clinic visit, Mental Status Exams/Psychological Evaluations, review of records, scoring and interpretation of behavior ratings, and report preparation is billed at $325.00. Fees are $290.00 individual therapy and $195 for family therapy. Typically, therapy sessions are 45 to 60 minutes, and scheduled shorter or longer depending on the needs of the individual/s and billed accordingly. All fees are subject to change and some services (e.g., psychological treatment/assessment, attendance at legal proceedings, etc.) may be billed under a different fee

schedule. If you are requesting different services than described, please check with the office manger for the appropriate fee schedule prior to service being rendered.

Insurance
Many companies require pre-authorization by either the primary care physician or insurance company. It is the patient's responsibility to see that proper authorization has been received prior to services rendered. We strongly encourage you to contact your insurance carrier to specifically ask about your plan's mental health coverage, including number of sessions allowed, types of therapy permitted, and diagnoses not covered by your plan. Common codes billed include 90791, 90847, 90837, and 90832. If psychological testing is conducted, contact your insurance company to determine whether they cover the code 96101. Some insurance companies exclude certain diagnoses. Feel free to request the diagnosis given at the end of the first session.

Request for Adjusted Fee
In the event that you do not have health insurance or other third party coverage, your fee will be determined in your first session. Agreed upon fee amount per session _____ (entered by office manager).

No Show or Cancellation within 24 Hours of Services
A $50.00 fee will be charged for all "no show" appointments and for appointments cancelled within the 24 hours prior to services being rendered. This applies to ALL patients. Few exceptions apply and this is at the discretion of your therapist.

Financial Responsibility & Assignment of Benefits
I understand that I am responsible for payment for all mental health care services provided to me by BHS. I hereby assign to BHS any insurance or other third-party benefits available for mental health care services provided to me. If theses benefits are not assigned to BHS, I agree to forward to BHS all health insurance and other third-party payments I receive for services rendered to me immediately upon receipt.

Medicare/Medicaid Benefits
I certify that the information given to apply for Medicare/Medicaid benefits is correct. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration, its intermediaries, or carriers any information needed for this related Medicare/Medicaid claims. I request that authorized benefits be paid on my behalf.

Authorization for Release of Information
I authorize BHS to release all treatment information requested by my health insurance carrier, Medicare/Medicaid, or any other third party payors. I authorize BHS to contact my insurance company or health administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information to BHS.

Consent for Treatment
I have read and understood all of the above information and agree to the provisions as described. I have had an opportunity to ask questions about the terms of this agreement. I consent to behavioral health care by BHS staff and acknowledge that no guarantees have been made to me as the result of diagnoses, treatments, or evaluations.

Notice of Privacy Practices
_____ I acknowledge receipt of the Notice of Privacy Practices by signing below.
_____ Notice of Privacy Practices was provided at initial intake visit.
_____ Acknowledgement of Notice of Privacy Practices not received. Reason: _____
Describe good faith effort to obtain acknowledgement: _____

Name of patient _____ Date _____

Authorized Signature _____ Relationship to patient _____