Solutions
Counseling & Consultation Services

_____
Patient Name

CONFIDENTIALITY: All counseling services are considered confidential. This confidentiality extends to the clinical supervision of your treatment. Information cannot be released to anyone outside this practice without your written permission, except as mandated by law (such as child abuse), or to prevent a clear and present danger to yourself and/or another. The signature of a parent or guardian is required for children who are under the age of eighteen (18). The signatures of both the patient and parent/guardian are required if the patient is 14-17 years of age. I understand that information relating to my treatment at Solutions, i.e. psychotherapy notes, may be communicated to my primary care physician, my insurance/behavioral health company, EAP and my referral source. If I received behavioral health care in the past, I will contact that treatment provider and have that information forwarded to Solutions Counseling. I am aware that Health Insurance Portability and Accountability Act (HIPAA) information regarding the privacy of my health information has been made available to me. In order to service your account or to collect monies you may owe, our office/agents may contact you by telephone at any number associated with your account, including wireless numbers, which could result in charges to you. We may also contact you by sending text messages or emails which you have provided. Methods of contact may include pre-recorded/artificial voice messages and/or use of automatic dialing devices.

APPOINTMENTS/CANCELLATIONS: An extended period of professional time has been set aside for you. It is very important that you arrive at your specified time so that we can utilize as much of your scheduled time as possible. Cancellations with less than 24 hours notice or missed appointments are your responsibility and cannot be billed to your insurance company. You will be billed a late cancellation fee of $50.00 for an appointment canceled if less than 24 hours notice is given.

PSYCHIATRY: Appointments with the psychiatrist are for medication management only and you must be in therapy here at least twice each year to continue seeing Dr. Behar. Scheduling is your responsibility and if you have not seen one of our therapists at least twice each year any Dr. Behar appointments may be cancelled until you have met these requirements.

PAYMENT AND INSURANCE: Payment is expected at the time of each visit to avoid a $5.00 billing fee. It is your responsibility to contact your insurance carrier to determine what coverage you have, specifying "outpatient psychotherapy", and obtaining authorization (if required). We will submit billing to your insurance, but you are ultimately responsible for payment should your insurance company deny any claim. Your signature authorizes your insurance carrier to pay your practitioner directly. **Any bill with final notice will result in the use of a collection agency after a 7 day period of non-payment and all future appointments will be cancelled.** The fee charged is a legal and lawful debt and will include a 23% collection fee.

If my child is from a separated/divorced family where legal custody is shared, I agree to inform the other parent about this treatment. I understand that my signature gives permission for treatment.

_____ _____
Patient signature (14 and older) Date

_____ _____
Parent/guardian signature (if under 18) Date

Please complete the following as a PAYMENT OPTION: ***(OPTIONAL)***
I authorize Solutions Counseling & Consultation Services to keep my signature on file and to charge my VISA/ MASTERCARD/DISCOVER/AMERICAN EXPRESS account for any unpaid charges.

_____ _____
Patient/guardian signature Date

_____ _____ _____
Account number Expiration date CVV