Easton Neuropsychology and Behavioral Services
299 Industrial Drive, Nazareth, PA 18064
(610) 504-6122

Informed Consent and Authorization for Treatment

AGREEMENT

By signing this agreement below, you are agreeing to enter behavioral health treatment with our practice. This may include individual ongoing psychological treatment, psychological evaluation, neuropsychological evaluation, or other services fully disclosed to you under the professional scope of our practice. Your responsibility is to attend scheduled appointments, participate to your fullest extent, and fulfill payment obligations,

FINANCIAL OBLIGATIONS

We are on panel ("in network") for many major insurance companies. If you use your insurance for services, you will be responsible for the co-pay and/or deductible at the time of service, as well as for any balance not ultimately paid by the insurance company. Our billing service will submit claims on your behalf.

By signing this agreement, you are allowing us and/or our billing representative to contact your insurance company. You are agreeing to assign insurance benefits for services rendered to us and Easton Neuropsychology and Behavioral services, LLC. You are authorizing release of information necessary to obtain payment from your insurance company on your behalf. Please understand that your health insurance is a contract between you and your insurance company. Therefore, you are responsible for payment of services which your insurance denies. While we may provide assistance with insurance processing, please understand that it is your responsibility to keep track of the number of visits, authorizations (if your insurance company requires them), plan limitations and yearly and lifetime maximums. Also, it is important to know that your insurance company represents a third-party interest and may access your files. We will take all allowable precautions to protect your privacy.

An initial diagnostic assessment is billed at a rate of $165.00. Psychotherapy sessions are 45 or 53 minutes, unless otherwise specified, and are billed at a rate of $135.00/$180.00 (sessions under 45 minutes are billed at a rate of $125.00). Psychological and Neuropsychological Evaluation are billed at the rate of $150 per hour: which includes testing time, scoring, and report writing, some of which occur after your face-to-face evaluation ends. The total rate for these services will be given to you prior to the start of your evaluation.

If you are not using your insurance, do not have insurance, or are experiencing financial hardship, we will be happy to work with you to try to make services more affordable. This may include temporarily reduced fees and payment plans. Without insurance/ in time of financial hardship the initial assessment is: _____ each additional session is: _____.

Certain services, such as other report writing, filling out forms on your behalf, court or legal testimony, photo copying, and other activities that may be required in conjunction with your treatment, will incur an extra charge that will be disclosed to you prior to the time that these services are performed

When an appointment is scheduled, the time is reserved for you alone. Therefore, you will be charged the current no show fee, which is posted in our office, for sessions where you don't show and/or are not cancelled within 24 hours of the scheduled session. This charge WILL NOT be paid for by your insurance company. You are personally responsible for this payment in full. You will not be permitted to schedule another appointment until your balance is met in full. Also, if you fail to show and/or call for two consecutive sessions we will be forced to close your file. At this time payment is accepted in cash, check, Visa, Mastercard, American Express or Discover card. Returned checks are subject to a fee of $30.00.

Also, by signing this agreement you acknowledge that if your account is submitted to an attorney or collection agency, or to litigate in court, or if your past-due status is reported to a credit reporting agency, the fact that you received treatment at my office may become a matter of public record.

In the event of divorce or separation, the party responsible for this account prior to the divorce or separation remains responsible for this account.

EMERGENCIES
We provide telephone coverage during crisis. Please call 610-504-6122. However, there may be times when you cannot reach us. If you are experiencing a true emergency or crisis that may put you at risk for harm, it is your responsibility to go to the nearest emergency center or call 911 first. Under situations that do not put you at risk for harm, but where you are unable to reach us, it is also your responsibility to go to the nearest emergency center or call 911.

CONFIDENTIALITY
In general, the privacy of all communications between a patient and a licensed mental health provider is protected by law, and we can only release information about our work to others with your written permission.

But there are a few exceptions. In most legal proceedings, you have the right to prevent us from providing any information about your treatment. However, in some proceedings, a judge may order my testimony if he/she determines that the issues demand it.

There are some uncommon situations in which we are legally obligated to take action to protect others from harm, even if we have to reveal some information about a patient's treatment. For example, if we believe that a child, elderly person, or disabled person is being abused, we must file a report with the appropriate state agency. If we believe that a patient is threatening serious bodily harm to another, we are required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient. If the patient threatens to harm himself/herself, we may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.

We may occasionally find it helpful to consult other professionals about a case. During a consultation, we make every effort to avoid revealing the identity of my patient.

RISKS ASSOCIATED WITH TREATMENT
Psychological and neuropsychological services can have benefits and risks. Since they may involve discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, these services have also been shown to have benefits for people who go through them, such as better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

I, the undersigned, have insurance coverage with _____ and assign directly to Easton Neuropsychology and Behavioral Services, LLC all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize Easton Neuropsychology and Behavioral Services, LLC to release all necessary information to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____
Beneficiary Signature Date