Cognitive Behavioral Therapy Services

Tel. (760) 730.0521 Chris Tammariello, LCSW (LCS19544) 2111 S. El Camino Real #302
Fax. (760) 730.0581 Oceanside, CA 92054

CLIENT ADVISEMENT FORM

Chris Tammariello, L.C.S.W. is a Certified Cognitive Therapist (#LCS19544) has been licensed to practice in California since 1999 and is the Director of this practice.

The following information clarifies issues relevant to the professional relationship and contract between you and your therapist. I will go over these issues with you again when we meet. Please let me know if any of these points are unclear to you or if you have any other questions about treatment. ***Please initial each blank space if you understand and agree with what is stated.***

CONFIDENTIALITY

In accordance with California law, the information disclosed by you in therapy is confidential and is not released or accessible to anyone else without your written permission. By law, the following exceptions apply and may require that relevant information is given to others: 1) danger to self, or risk of suicide; 2) danger to others; 3) indications of current/recent child or elder abuse, and sometimes indications of past abuse when someone may be at risk of such abuse presently. In other rare situations (such as a court order from a judge, or as indicated below) confidentiality may be limited.

____ I acknowledge that copies of the Health Insurance Portability & Accountability Act (HIPAA) Notice of Privacy Practices, which informs me of my rights regarding Protected Health Information (PHI) and Telehealth consent can be reviewed and printed from the *Forms* section at www.cbtservices-nc.com.

____ I understand that information regarding appointments, payments, diagnosis, treatment, address, telephone, and other information required by your insurance company for payments or reimbursements will be released.

____ I understand that I will be responsible for submitting the proper information to my insurance carrier for reimbursement. CBTS will provide me with any billing statements needed for this purpose. **Note: CBTS is not a Medi-Care provider (Opted-Out status), and all patients receiving services agree that they are prohibited by Medi-Care to submit claims for reimbursement.**

____ I understand that information regarding appointments, payments, diagnosis, treatment, address, telephone, and other information required for billing statements and managing your account may be viewed, but not kept by a support staff from Theramanger, .

____ I understand that if I require or request therapy services via telephone or via video conferencing that although my therapist and Cognitive Behavioral Therapy Services make effort to secure my information by using Hipaa compliant video conferencing services and making every effort to conceal and protect confidentiality, **the phone or email may not be secure and your confidentiality may be compromised.**

PAYMENT FOR SERVICES

____ I understand that my fee will be **$195** for each (45-50 minute) session, or **$60** for each group session. Extended sessions or non-emergency phone therapy will incur an additional prorated fee. Consultations with other professionals (e.g. Therapists, MD's), and preparation of letters or reports regarding your treatment, will also be billed at a prorated fee. I agree to pay in full for services rendered by Mr. Tammariello. Any checks that are returned due to insufficient funds will incur a **$30.00** return check fee.

____ I understand that I must make changes/cancellations for therapy appointments **24 hours in advance** and that I will be automatically charged on my card provided below a fee of **$95/50min** for individual/conjoint sessions and $30 for group sessions that are late changes/cancellations, missed or forgotten sessions. Regardless of the reason for changes, missed, or late cancellations, this fee is for the reservation of that appointment time. (Insurance companies will not pay for late cancels.)

Cognitive Behavioral Therapy Services

PAYMENT FOR SERVICES CONT'D

____ I understand that bills for sessions will be sent to the person listed below. Dates of sessions, codes for the type of service provided, and diagnosis codes may be included with each billing statement which is required for insurance reimbursement. No other information will be released without your written approval and/or in violation of the HIPPA law.

____ I understand that I must make changes/cancellations for therapy appointments **24 hours in advance** and that I will be charged a fee of **$95/50min, no matter the reason,** for individual/conjoint sessions and **$30** for group sessions that are late changes/cancellations, missed or forgotten sessions. Regardless of the reason for changes, missed, or late cancellations, this fee is for the reservation of that appointment time. (Insurance companies will not pay for late cancels.)

____ I agree that no show/late cancel/late change will be automatically charged to the payers credit card (below).

____I agree and understand that any uncollected bills will be charged to my credit card for services or missed appointments. In the case of any uncollected balances disclosure of my name, telephone number, SS#, and address to a collection agency or small claims court. I also understand that I am responsible for any bills that my insurance does not reimburse.

TREATMENT OUTCOME: There are no guarantees that treatment will be successful, although most clients do make significant progress. The length and outcome of treatment is based on your motivation for treatment, how long you have had the symptoms, the skill of the therapist, and other factors.

In Case of Emergencies: Please call Mr. Tammariello at **(760)-415-3071**. You may also call the **San Diego Crisis Line at (888) 724-7240. For all life threatening or medical emergencies please dial 911.**

I (WE) HAVE READ AND I UNDERSTAND THE INFORMATION ON THIS PAGE (PLEASE PUT INITIALS IN EACH STATEMENT ABOVE). I (CLIENT) WILL REQUEST A COPY OF THIS ADVISEMENT FORM IF SO DESIRED.

_____	_____	_____	_____
Signature of Client	Date	Chris Tammariello, L.C.S.W.	Date

Person responsible for payment if different from the above signed Client

_____	_____	Not ~~needed~~ _____	_____
Name of person responsible for payment	Relation to Client	~~Social Security~~ #	Date of birth
		( ) -	

_____

Address City, State, Zip Phone

_____

Billing Address (if different from above) City, State, Zip

Card# _____ Expiration date: ___/_____ Code: _____ Zip code_____

As the responsible person for payment, I understand and agree with the policies regarding payment for services and late cancel or change, or missed appointment fees of patient.

_____	_____
Signature of person responsible for payment	Date