

Cognitive Behavioral Therapy Services (CBTS)

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CLIENT ADVISEMENT FORM

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 I have received a copy of the Health Insurance Portability & Accountability Act (HIPAA) Notice of Privacy Practices, which informs me of my rights regarding Protected Health Information (PHI).

____ 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 Theramanager, .

____ I have given a copy of a ***Consent for Telehealth Services*** and 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 \$225 for each (45-50 minute) session, or **\$95** for each group session. Extended sessions, phone therapy, or therapy via email 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. If services are provided out of the office (in-home, exposure treatment) travel time will be billed at a prorated fee. I agree to pay in full for services rendered by a CBTS therapist . Any checks that are returned due to insufficient funds will incur a **\$25.00** return check fee.

Cognitive Behavioral Therapy Services, Inc.

PAYMENT FOR SERVICES (Cont'd)

___ I understand that I must make changes/cancellations for therapy appointments **24 hours in advance** and that I will be charged a fee of **\$110/50min, no matter the reason**, for individual/conjoint sessions including travel time. A **\$45 fee** 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 my credit card:

_____ Exp ___/____ Code _____ billing zipcode _____

___ 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 a non-emergency, after hour crisis: Please contact your therapist or call Mr. Tammariello at (760)-415-3071. **If case of an emergency, requiring immediate help please call: San Diego Crisis Line at (888)724-7240 or 741741 for the national crisis number. 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