

# Cognitive Behavioral Therapy Services

Tel. (760) 730.0521  
Fax. (760) 730.0581

Chris Tammariello, LCSW (LCS19544)

2111 S. El Camino Real #302  
Oceanside, CA 92054

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## 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](http://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 Theramanager, .

\_\_\_\_ 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.)

