SRI PSYCHOLOGICAL SERVICES, P.C.
THE PAVILION
261 OLD YORK ROAD, SUITE 318
JENKINTOWN, PA 19046
(215) 885-3337

PATIENT INFORMATION and SERVICE AGREEMENT

Our staff is dedicated to serving you in a professional and caring manner. The information provided here is intended to clarify our procedures. If you have any questions or concerns or if anything is unclear, please ask and we will be happy to discuss your concerns with you. Please sign below to indicate that you have read and agree with these polices.

1. Telephone messages: We make every effort to answer all calls during business hours, and to return all calls within one business day. Our main phone number is 215-885-3337. A voice mail system is available at this number 24 hours per day, 7 days per week. Follow the instructions to leave a routine message for your therapist. If you have an emergency, follow the instructions to be connected with the emergency operator who will then page the staff member on call.

2. Emails and Electronic Communication: If your therapist chooses to communicate with you by electronic device, (email, texting, cell phone, etc.), this form of communication will **only** be used for scheduling purposes. Please do not communicate anything, personal, confidential or therapy related using these forms of communication.

3. Confidentiality: All information obtained during evaluation and treatment sessions is confidential, subject to legal and ethical requirements. (See the limited exceptions in your consent and treatment privacy notice). Please note that insurance companies now require some information about your treatment. You will be asked to sign consent to release information to your insurance plan.

4. Sessions: The first session is usually an evaluation interview. Services that are offered here at SRI include; individual, family and couples counseling, psychiatric services and psycho-educational testing.

5. Legal Proceedings: Clinicians at SRI do not provide evaluations regarding competency, disability or child custody, fitness for work, nor do we participate in any legal proceedings. We will not release your child's records for the purposes of divorce or custody., nor provide legal testimony regarding these issues.

Financial Policy

6. Insurance reimbursement: Payment of fees or co-payments for services are **due at the time of each visit.** We accept cash, checks and credit cards as forms of payment. Upon request, we will provide you with a receipt if needed to obtain reimbursement. However, you (not your insurance company) are responsible for full payment of our fees. It is important that you find out exactly what mental health services your insurance policy covers. **Please let the office know immediately of any changes in your insurance coverage or co-payments.**
   Some insurance plans offer only limited coverage. It may be necessary to seek authorization for continued treatment after a certain number of sessions. Insurance plans **do not** cover services once benefits are exhausted. If you're not covered by insurance, you will be responsible for the fee as agreed upon with your therapist.

7. Overdue payments: If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, we have the option of using legal means to secure payment. This may involve hiring a collection agency or going to small claims court, which will require us to disclose otherwise confidential information. In a collection situation, the typical information we release about a patient's treatment is his/her name, the nature of services provided, and the amount due.

8. Canceled appointments: We ask that you call **24** hours in advance if you need to cancel an appointment. Failure to do so may result in a **$50 charge** to you for the missed session. You will not be charged if an illness or an emergency caused you to miss the appointment. It is important to note that insurance companies do not provide reimbursement for canceled sessions.

Print Name	Signature of Client	Date of Birth	Signature of Parent/Guardian	Date

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Consent to Treatment

Thank your for choosing SRI Psychological Services, P.C. This document is an acknowledgment of your understanding of our professional relationship. By signing this form you are giving consent for you or your child to receive treatment from SRI Psychological Services, P.C. If there is a court order of joint custody, or shared legal custody for a child under the age of 14, the consent of both parents is required to provide treatment.

Your clinical information is confidential with the following exceptions; 1) If there is a danger to yourself or others, 2) mandated child abuse reporting, 3) a court order to disclose information. In accordance with the recently amended child abuse laws, if SRI therapists have reason to suspect that a child has been abused, they are required to report their suspicions to the authority or government agency vested in conducting child abuse allegations. Your therapist is required to make such reports even if they do not see the child in their professional capacity. Your therapist is mandated to report suspected child abuse if anyone aged 14 or older reports that he or she committed child abuse even if the victim is no longer in danger. Your therapist is also mandated to report suspected child abuse if anyone reports that he or she knows of any child who is currently being abused.

By signing this form you consent for your therapist to consult with other SRI clinical staff as needed, and acknowledge that support staff has access to all files. If you are referred by another clinical professional in this practice, staff may consult regarding your case.

You are also authorizing release of information to your healthcare insurance provider as required for authorization of recommended services and payment of claims, or to collect overdue fees. There are times when formal business associates (such as but not limited to; billing software companies, pharmacies for medication information, or the after hours answering service), may have some limited access to your protected healthcare information, although they are legally bound to keep it confidential. (Protected health information (PHI) under US law is any information about health status, provision of healthcare, or payment for healthcare that is created or collected by a covered Entity" (or a Business Associate of a Covered Entity), and can be linked to a specific individual). You have the right to see, make copies of or ask for amendments to your protected health information. All requests must be in writing. However, your therapist has the right to withhold any information that may be detrimental to you, or if it will endanger the life or safety of an individual.

Your records are protected under HIPAA and the applicable State law governing health care and mental health services and under the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without your written consent unless otherwise provided for in state or federal regulations. You may revoke this consent, in writing, at any time except to the extent that action has been taken in reliance on it.

This authorization shall remain in effect for duration of treatment.

_____	_____	_____	_____	_____
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AUTHORIZATION TO RECEIVE AND RELEASE INFORMATION

This section of the form, when completed and signed by you, authorizes SRI to receive and release protected information from your clinical record to the person you designate.

I authorize SRI Psychological Services to:

(Please check one or both) release information_____ obtain information_____

(Provide specific information you want disclosed) (check all applicable or specify below)
___treatment notes,___ treatment summary, ___evaluation reports, ___all information
_____

This information should be released to or requested from *(name and address of person(s) to whom the information is to be released/requested)*_____

_____

I am requesting the release of this information for the following reasons (check all applicable or specify below);

____for treatment purposes, ___for continuity of care, __other (specify below)
_____

This authorization shall remain in effect for until the end of treatment unless otherwise indicated here.

_____

You have the right to revoke this authorization, in writing, at any time by sending such written notification to our office address. However, your revocation will not be effective to the extent that we have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
I understand that SRI Psychological Services generally may not condition services upon my signing an authorization unless the services are provided to me for the purpose of creating health information for a third party.
I am aware that this information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by the Privacy Rule. I understand that I have a right to cancel this authorization by writing to: The Pavilion 261 Old York Road, Suite 318 Jenkintown, PA 19046. However, this revocation will not be effective to the extent to which actions have been taken in reliance on this authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my psychologist, health plan, or other covered entity may not condition treatment, payment, enrollment or eligibility of benefits upon my signing the release except a health plan may condition enrollment upon the provision of an authorization to determine underwriting risks, or for creating protected health care information for disclosure to a third party (such as a physical examination as a condition of pre-enrollment in a life insurance policy).

_____	_____	_____	_____	_____
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