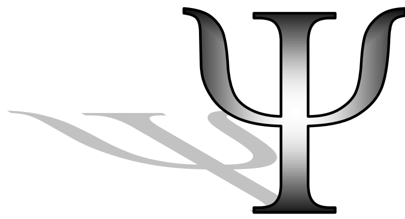

MEDICAL PSYCHOLOGY CENTER
570 Memorial Circle, Suite 150
Ormond Beach, Florida 32174
Phone: (386) 672-9250 Fax: (386) 672-9251

OUTPATIENT SERVICES CONTRACT/CONSENT FOR TREATMENT

Welcome to the Medical Psychology Center. This document contains important information about our professional services and business policies. **Please note that when you sign this document, it will represent an ongoing agreement between you and your provider**.

MEETINGS and CANCELLATIONS: In order to secure your most preferred appointment time, we advise patients to schedule appointments in advance. Scheduling an appointment indicates a commitment to attend the appointment. Once an appointment is scheduled, we require 48 hours (2 business days) notice on cancellations. Our answering machine receives calls 24 hours a day. We understand that emergencies do occur and this will be considered by your provider on a case by case basis. To avoid a $75.00 late cancellation fee, please call our office two working days in advance if you need to cancel. Reminder calls from our office are made as a courtesy only. We do not guarantee that a reminder call will be made.
By initialing here, I acknowledge that I have read and agree to this policy. ____________

BILLING AND PAYMENTS: You will be expected to pay your portion of each session before the session is held, unless an advanced agreement is made. If you are unable to pay for your portion of the visit at the time of the visit, future appointments will not be scheduled until your payment is received. If you anticipate that you may have trouble paying your bills on time, please discuss this with your provider. **Delinquent accounts:** If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, your provider will forward all outstanding bills to a collection agency. If you are in default regarding payment of rendered services, you will be notified of the intention to contact a collection agency, and hopefully a payment plan can be arranged. The only information that will be released to a collection agency regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. If forwarded to a collection agency you will owe the outstanding balance plus any fees charged by the collection agency.
By initialing here, I acknowledge that I have read and agree to this policy. ___________

INSURANCE BILLING: We will provide you with whatever assistance we can in helping you to receive the insurance benefits to which you are entitled. However, you (not your insurance company) are responsible for payment of services rendered.
(Providers-please check one of the following two options)

____ **In-network insurance reimbursement patients:** If your provider is contracted by your insurance company, he/she will accept the rate permitted by your company including coinsurance and co-pay. Where applicable, you will be expected to pay coinsurance and co-payments before the beginning of each session. I give my provider and the staff of Medical Psychology Center permission to contact my insurance company with the intent to claim insurance benefits and obtain authorization for treatment and/or testing. I understand that I can revoke this consent at any time.

____**Out of network insurance patients**: At the end of each session, we will provide you with a Superbill (billing statement) to submit to your insurance. Full agreed upon payment is due prior to the onset of your appointment. We will assist you in addressing your insurance questions as possible. However, we cannot guarantee that out of network insurance companies will reimburse you for services.

CONTACT INFORMATION: The office telephone is answered by voice mail and by our office staff. With the exception of weekends and holidays, every effort will be made to return messages within 24 hours. If you are unable to reach us and feel that the situation is an emergency, contact your family physician or the nearest emergency room and ask for the mental health specialist on call.

CONFIDENTIALITY: Please see the form called "Medical Psychology Center Policies and Practices to Protect the Privacy of Your Health Information." Your provider may occasionally consult with and/or receive supervision from other mental health professionals. When such supervision/consultation occurs, identifying information such as name, date of birth, social security number, etc. will be withheld in order to insure patient privacy. Patients will be notified in advance when services they are receiving are being supervised.

I have received and have been given an opportunity to read a copy of Medical Psychology Center Policies and Practices to Protect the Privacy of Your Health Information (HIPPA regulation form). I understand that if I have any questions regarding the Notice or my privacy rights, I can contact the Office Manager or my provider.

____ ____

Patient/Client Date **Parent, Guardian or Personal Representative * Date**

* Please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

❑ **Patient/Client Refuses to Acknowledge Receipt:** (Staff member sign and date)__________________________

INFORMED CONSENT FOR TREATMENT AND EVALUATION (testing):

a. *I have had explained to me and I understand the concepts and conditions of informed consent, privacy, privilege, and confidentiality. I have been given the opportunity to discuss these concepts and conditions and to ask questions about them.*
b. *I have been informed of the goals, expectations, procedures, benefits, and possible risks involved with receiving a psychological/neuropsychological evaluation. Mental health evaluations frequently involve self-disclosure and can be frustrating at times. My evaluation has the primary goal of identifying strengths and weaknesses and to assist with the diagnosis of medical conditions (including dementia).*
c. *I have been informed of the goals, expectations, procedures, benefits, and possible risks related to being treated with psychotherapy, biofeedback, neurofeedback, EMDR, hypnosis and/or cognitive rehabilitation. These services are interactive processes that frequently require self-disclosure, self-exploration, and responsible action. They have the overall purpose of promoting understanding and change. Sometimes this process can be stressful and emotionally painful, and at other times very fulfilling.*
d. *I have the right to refuse any counseling, psychotherapy, evaluation procedures, or intervention unless otherwise specified by law.*
e. *I have the right to question any procedure, intervention, rationale, or discussion that is unclear or that I do not understand.*
f. *I understand that all communication will be private, legally privileged, and confidential unless otherwise specified by law or unless I provide my written consent for a specific release of information.*
g. *I understand that Dr. Sofia Yahya is a licensed Medical Doctor, that Lana Brown is a Licensed Mental Health Counselor, and that Drs. Katherine Billiot and Nancy Voight are licensed as Psychologists in the State of Florida. These mental health providers are mandated reporters of imminent suicidal/homicidal risk and elder/child abuse, neglect, or exploitation.*
h. *I understand that this consent may be withdrawn by me at any time without prejudice.*
i. *We may disclose your health information to authorized federal officials who are conducting national security and intelligence activities or providing protective services to the President or other important officials. By law we cannot reveal when we have disclosed such information to the government.*

Name: (Print)__________________ Date of Birth:________ Signature:___________________ Date: ______

Modified 20 June 2014