INSIGHT PSYCHOLOGICAL GROUP

David Helfgott, Psy.D. LLC
773 Central Avenue
Westfield, NJ 07090
Ph: 908.228.2740 Fax: 908.721.0490
Email: office@insightpsychgroup.com
www.insightpsychgroup.com
Tax ID: 46-5382812

PATIENT CONSENT FORM

I _____ acknowledge the following rules and procedures of Insight Psychological Group (IPG):

1) **Length and Frequency of Treatment:** Sessions typically last 45-50 minutes and are usually scheduled for once per week. Depending on the nature of the problems being addressed sessions may be longer, or more or less frequent. Group, Couples and Family Therapy are usually longer than individual sessions.

2) **Confidentiality:** All information shared in treatment is kept confidential except when:
   1. You or your legal representative sign a written release of information
   2. You are a danger to yourself
   3. You are a physical danger to others
   4. Child or elder abuse is suspected

3) **Fees and Insurance Coverage:** We are in-network with some insurance plans, not all. It is your obligation to determine what will and will not be covered at Insight. (Group Psychotherapy at IPG is not run through insurance and will not be covered). Your **Session Rate** is either: our regular fee, or that discounted by your insurer when in-network, or that reduced in circumstances of hardship. Our office will inform you of your estimated copay, coinsurance or deductible amount to be paid at the time of each service. Final patient responsibility determinations are made upon successful completion of processing of your insurance claim by your insurance carrier(s). Your signature at the bottom of this page indicates your consent for us to submit information required by your insurance to process your claim. Our regular fees are:

   - Initial session (60 minutes): $200
   - Individual session (45-50 minutes): $150
   - Family/Couple sessions (60 minutes): $175
   - Group Psychotherapy (60-90 minutes): $60
   - Hourly rate for report preparation or collateral consultations: $150 (prorated)

4) **Missed/Cancelled Session Policy:** Your scheduled time is reserved for you exclusively. Missed sessions by law cannot be billed to your insurance and you will be expected to pay your **Session Rate** when you do not attend. Some of our practitioners allow for cancellations or a rescheduling with at least 24-hours' notice, and may allow for a reduced Late Cancel/No Show fee of $50 applied to your bill in lieu of paying your Session Rate. Please ask your therapist what his or her particular Missed/Cancelled Session policies are within IPG. In cases of emergency, your responsibility may be waived at your therapist's discretion.

5) **Credit Cards:** In addition to cash or check, we accept all major credit/debit cards. Payment is due at the time of service. If you wish to wait until an insurance carrier processes your claim to determine final responsibility, a credit card must be kept securely on file with our office. Credit cards will be charged for: (*You will be notified by email each time your card is charged)*

   - Co-payments or co-insurance payments required by your insurance company that were not paid at the time of service.
   - Deductible your insurance company did not pay.
   - Scheduled appointments you did not attend.
   - The amount your insurance reimburses for our sessions, if and when the check is mailed to your home and you haven't forwarded that check or amount to our office within two weeks.

6) **Emergencies:** In emergency situations, you must call 911 or 973-540-0100 to speak with a crisis counselor. However, in non-life threatening but urgent situations, you may call your therapist between sessions. Phone calls lasting more than 10 minutes will be charged at our regular hourly rate ($150) and cannot be billed to insurance.

7) **Consent for Treatment:** I have been given a copy of IPG's *Notice of Policies and Practices to Protect the Privacy of Your Health Information*, and my rights and responsibilities have been explained. I have also been given a copy of *Office Policies and Treatment Practices*. I understand the pros and cons of treatment and the rules and conditions of IPG's practice. I understand that non-compliance with IPG's rules and conditions will make my treatment subject to termination and referral to an appropriate outside practice. My signature below is my agreement to the above terms and consent to take part in treatment.

_____

Client/Parent/Guardian Signature **Date**

_____

(Authorized representative for IPG) Date