Insight Psychological Group David Helfgott, Psy.D. LLC
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PATIENT CONSENT FORM

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Name of Patient **Date of Birth**

The following are the basic policies and procedures of Insight Psychological Group (IPG). Please read through them, initial, and sign at the bottom of the form.

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:
    a. You or your legal representative sign a written release of information
    b. It is believed you are a danger to yourself or to others
    c. Child or elder abuse is suspected
    d. Occasional case consultations between therapists at IPG. However, every effort is made to thoroughly conceal your identity.

3. **Fees and Insurance Coverage:** We are in-network with many insurance plans, but not all of them. It is your obligation to know what your insurance will cover. You may also contact our Billing Department at any time to help guide you: (908) 228-2740. Group Psychotherapy, Testing/Assessment or Parent Coordination Services at IPG are not run through insurance and must be paid for out-of-pocket. Your Patient Responsibility is either: 1) our regular fee, or 2) a reduced fee in circumstances of hardship (as decided by our Director), or 3) your cost sharing amount based on your insurance plan. Our office will inform you what your estimated Patient Responsibility is which you will need to pay at the time of service. All final determinations of your financial responsibility for services will be made after your insurance has completed processing your claim. Should your insurance coverage change at any time, you are required to notify us. You will be responsible for any fees incurred if you do not notify us of any change in your insurance and non-covered services are rendered

4. **Our regular fees are:**
    - Initial session (60 minutes): $200
    - Standard individual session (45-53 minutes): $150
    - Extended Indiv./Family/Couple sessions (60 mts): $175
    - Group Psychotherapy (60-90 minutes): $60
    - Returned Check Fee: $25
    - Testing/Assessment/Report Preparation/Collateral consultations (phone calls): $150 per hour (prorated; minimum 15 minutes)
    - Parent Coordination: $250 per hour
    - Late Cancel/Missed Session Fee: $50

5. **Credit/Debit Cards:** IPG requires all clients to store a valid credit/debit card on file in advance of their first appointment in order to reserve session times with our therapists. But clients may also receive invoices and pay via the Patient Portal; please see Payment Authorization Form. Unless paid within two weeks, or have other written payment arrangements made, your card on file will be billed any and all of the following:
    - Any copays or coinsurance amounts as specified by your insurance plan that were not paid at the time of service.
    - Deductible amounts which your insurance plan has, as determined after successful processing of your claim.
    - Any Late Cancellation or Missed Appointment fees.
    - The amount your insurance reimburses you on an out-of-network basis 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 of receipt.
    - Bank fees or charges associated with bounced or returned checks.

6. **Rescheduling/Cancelled or Missed Sessions/Overdue Balance Policies:** Your scheduled time is reserved for you exclusively. All cancellations or rescheduling must be done with at least 24-hours' notice. Please contact your therapist directly to cancel or change an appointment. Missed sessions by law cannot be billed to your insurance. Unless specially waived at the discretion of your therapist, you will be charged the Late Cancel/No Show fee of $50.00 in these circumstances. Your credit card will be charged this fee. For any balance owed, if payment is not made, then at the discretion of IPG, your treatment may be paused until payment is made in full or a payment plan is arranged.

7. **Emergencies and Phone Contact:** 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 contact your therapist between sessions. Phone calls/video calls with your therapist or for calls they make on your behalf to help in your treatment (with physicians, teachers, etc.) which last more than 15 minutes will be prorated and charged at our regular hourly rate ($150) and may be billed to insurance, if applicable, generating a copay or coinsurance.

After reviewing the information above, please read and initial *all* statements below, indicating your consent, and sign at the bottom.

_____ I have had the opportunity to ask questions about these policies and procedures, as well as about the pros and cons of receiving psychotherapy. 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 represents my authorization to partake of treatment at IPG. I understand I have a right to withdraw my consent at any time in writing.

_____ I understand that IPG will need to share confidential information with third parties, such as my insurance carrier(s), in order to authorize and reimburse my sessions. These third parties have a right to review my treatment at any time. My signature below also authorizes the release of this information in order to process my sessions, and for payment to be made directly to IPG for services rendered.

_____ I understand that I am ultimately financially responsible for my treatment services at IPG to pay any balances owed after all third-party payments have been applied, or should any third-party payer decline to pay for some or all of my treatment. I understand that IPG reserves the right to send any delinquent balances and accounts to a collections agency with whom I may not have any previous relationship. I may be billed additional fees associated with the collection of my balance.

_____ I have had the opportunity to review and ask questions regarding IPG's *Notice of Policies and Practices to Protect the Privacy of Your Health Information,* and I understand my rights as a patient.

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Name of Patient

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Name of Parent/Guardian (if applicable)

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Client/Parent/Guardian Signature **Date**

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(Authorized representative for IPG) Date