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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, Frequency, Format and Location 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.

   Telehealth psychotherapy has been found to be effective in treating a wide range of disorders, and there are potential benefits to it including easier access to care and protection from infectious diseases. At the beginning and throughout your treatment, your clinician will assess if telehealth treatment is an appropriate level of care for your therapy needs. If it is not, in-person sessions will be advised. As with all medical treatments, there is no guarantee that any particular treatment will be effective for all patients.

   If your treatment is via telehealth, a HIPAA-compliant secure telehealth platform will be used, and instructions will be sent to you how to access your session. If a unique link is sent to you for these purposes, you agree not to share this link with anyone not authorized to join the session. Each session, you must notify your therapist of your location. You will be expected to ensure the privacy and confidentiality of the environment you are in, make sure it is distraction-free, and to disclose to your therapist if any possible third-party, human or electronic, might overhear your session. You must agree to not record your session without prior consent of your therapist. For all telehealth sessions, you must identify to your therapist the name and phone number of an emergency contact near your location who may be contacted in the event of a crisis to assist in addressing the situation.

   When sessions occur in-person, a separate *Consent Form for In-Person Psychological Services* will be given to you to fill out.

2. **Fees and Insurance Coverage:** We are in-network with many insurance plans, but not all of them. You may contact our Billing Department at any time to help guide you. 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 Responsibilit*y 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 can inform you what your estimated Patient Responsibility will be before services are rendered. Our fees for telehealth therapy are the same as in-person. Most insurances now provide coverage for telehealth.

   While it is our obligation to contact your insurer before engaging in treatment to determine if there are applicable co-pays or fees which we are required to collect, it is ultimately your responsibility to know what your insurance will cover. All final determinations of your financial responsibility for services are made after your insurance has completed processing your claim. If your insurance, HMO, third-party payor, or other managed care provider does not cover your treatment, you will be solely responsible for the entire fee of the session. 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.

   Our regular fees (in-person and teletherapy) 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
   - Evaluations/Letter/Report Preparation/Collateral consultations (phone calls): $150 per hour (prorated; minimum 15 minutes)
   - Parent Coordination: $250 per hour
   - Scheduling Fee for Appointments not kept: $50

3. **Invoices and Credit/Debit Cards:** IPG requires all clients to keep a valid credit/debit card securely on file with our offices at all times in order to reserve session times with our therapists. Patients must use our Payment Authorization Form to safely place this card in our files. After your session, once your final balance is determined (following completion of insurance claim processing if applicable) your balance is ready to be invoiced. Invoicing at IPG is done monthly, with invoice-due dates typically set for the beginning of each month. You will be sent instructions how to log into your Patient Portal. All clients are encouraged to review and/or pay each invoice through their portal. Once the payment due date arrives, any unpaid invoices will be charged to your card on file, unless a payment arrangement has been made beforehand. These charges may include:
    a. Any copays, coinsurance or deductible amounts as specified by your insurance plan following successful processing of your claim. If no insurance is used, our regular fees, unless otherwise specified.
    b. Any Scheduling Fees for Appointments not kept.
    c. 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.
    d. Bank fees or charges associated with bounced or returned checks.
4. **Overdue Balance and Pausing Treatment:** IPG reserves the right to pause the treatment of any client who has an overdue, unpaid balance. Our offices will attempt to contact the client, as well as notify the client's therapist, in order to give advance notice and opportunity to make payment arrangements so that treatment can continue.
5. **Confidentiality:** All Personal Health Information and contents of sessions are 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 or neglect is suspected
    d. During occasional case consultations between therapists at IPG. However, every effort is made to thoroughly conceal your identity.

    Please note: While the nature of treatment at IPG is *not* normally collaborative between therapists, in cases of family members being seen by different providers, there is no assumed guarantee of confidentiality between providers regarding their treatments.
6. **Rescheduling/Cancelled and Missed Sessions:** 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. If you skip or cancel the session within 24 hours of its scheduled time, a Scheduling Fee of $50 will be added to your invoice, *as the appointment was reserved for you without otherwise billable services rendered*. In some circumstances, your therapist may offer a replacement session within the same week if their schedule allows.
7. **Communication and Notification Policies:** By being a client of IPG, you agree to receive text and/or email communications from our offices regarding scheduling, billing, and practice-wide announcements or policy changes. Occasionally, we may also send articles of interest or links to pertinent mental health topics for your benefit. When emailing or texting our clients individually, we utilize only fully HIPAA-compliant software to ensure confidentiality, privacy and trackability. We can be responsible for the privacy of your information only when it is on our systems or in-transit. You must ensure the privacy of the information when it resides on your own device.
8. **Emergencies and Phone/video contact not during a session:** IPG treats only clients who are able to maintain adequate, basic self-care and function independently or with the immediate and available help of a loved one through the week. Clients are seen by our therapists no more than twice weekly, and this frequency of contact is expected to be sufficient to support our clients emotionally and psychologically. If a client's symptoms are such that more support is necessary, psychiatric consultation or referral to a higher level of care will be advised.

    Nevertheless, you may reach out to your therapist between sessions for urgent, but not life-threatening matters. We will do our best to return all calls within 24 hours. Phone calls/video calls with your therapist which last more than 10 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. Similarly, calls your therapist makes on your behalf to help in your treatment (with physicians,

teachers, etc.) will be billed in the same manner. In any case, in emergency situations, where your life or stability is at risk, you must call 911 or 973-540-0100 to speak with a crisis counselor, or head to an emergency room. Do not call your therapist at these times. The crisis clinician will be in touch with your therapist to inform them of the situation.

9. **Social Media and Reviews:** Due to concerns about confidentiality and privacy, as well as potential conflict of interest, IPG practitioners in their personal capacities do not accept friend or contact requests from current or former clients on social networking sites (Facebook, Twitter, Instagram, LinkedIn, etc.). In the same vein, we do not respond to messaging or wall postings from clients on these sites in order to maintain your confidentiality and your therapist's individual privacy, and to not compromise your treatment. Our therapists do not "google" or otherwise look up information about our clients. We discourage the posting of any reviews about our practice or your treatment online, whether positive or negative, while you are in treatment with us, and for confidentiality reasons we are not permitted to respond directly to reviews posted about IPG or any of its practitioners.

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 agree to comply with these rules and conditions, and I understand that non-compliance with them will make my treatment subject to termination. 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 if my services are provided via telehealth, there are inherent risks including interruptions, unauthorized access, and technical difficulties, as well as increased challenges should a crisis or emergency arise. I will not hold IPG responsible for the technological problems it has no control over. I understand that if I or my child demonstrates an exacerbation of symptoms, or if I do not follow the above rules for telehealth services, telehealth sessions may be discontinued, and in-person treatment or a referral to a higher level of care may be necessary. In such circumstances, if IPG cannot provide in-person treatment, a referral will be made to another practice.

_______ 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 may 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 **Name of Parent/Guardian (if applicable)**

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Client/Parent/Guardian Signature **Date**

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(Authorized representative for IPG) Date