2525 Harbor Blvd. #208
Port Charlotte, FL 33952
(941) 255-5489

PEACE RIVER PSYCHOLOGY CENTER

5971 Cattlemen Lane
Sarasota, FL 34232
(941) 505-6162

Daniel Goldman, Ph.D.
Licensed Psychologist, PY8470

INFORMED CONSENT FOR TREATMENT and FINANCIAL AGREEMENT

CONFIDENTIALITY

Please see *Florida Notice Form for the Health Insurance Portability and Accountability Act* provided.

CONFIDENTIALITY REGARDING MINORS AND PARENTS

The law may allow parents to examine a child's treatment records when the child is a patient under 18 years of age who is not emancipated. Privacy in psychotherapy is often crucial to successful progress. Thus, before giving parents any information, Dr. Goldman will discuss this with the child, if possible, and do his best to handle any objections that the child may have. If Dr. Goldman believes that a child is in imminent danger or is a danger to someone else, he will immediately notify the child's parents of this concern.

*** Initial _____**

EMERGENCIES

Peace River Psychology Center is an outpatient care practice that operates during traditional business hours and does not offer 24-hour availability. As such, Dr. Goldman may be unavailable in the case of an emergency. If you should experience a crisis and Dr. Goldman cannot be reached immediately, you should go to your local hospital emergency room or call 911.

*** Initial _____**

INSURANCE / BILLING POLICIES

Dr. Goldman is a provider for some, but not all, insurance companies. In checking your benefits, we use tools provided by the insurance companies. The benefit information we receive from your insurance carrier is advisory only and not a guarantee of coverage or payment.

The amount you pay depends upon the length of the session and upon your insurance. The fee billed to your insurance for an initial evaluation is $175.00, $150.00 for additional visits lasting 52-60 minutes, and $75 for appointments lasting 16-37 minutes. If Dr. Goldman is a provider for your insurance, you will be required to pay any copays or deductibles owed at the time of your visit. All patients are responsible for charges not covered by insurance which are allowable by contract and by law. Your insurance carrier will initially be billed for the full fee, and once payment is received from your carrier, the fee will be adjusted to the contracted rate. (Medicare patients are advised that Medicare only pays for 80% of the allowable Medicare rate. You are responsible for paying the remaining 20% if you do not have a secondary insurance that will cover that amount). If Dr. Goldman is not a provider for your insurance carrier, we will gladly submit a claim to them as a courtesy to assist you in receiving any out of network benefits available to you. We understand that at times the need for therapy may be accompanied by financial difficulties. If you are having financial problems, please discuss this with our office staff.

*** Initial _____**

Dr. Goldman will not provide evaluations or provide endorsement statements for the purpose of securing special benefits (e.g., Social Security disability, disability insurance policies, therapy dogs, etc.). If you anticipate needing a doctor to endorse you for special services, please discuss this with Dr. Goldman before initiating therapy.

*** Initial _____**

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CANCELLATIONS AND MISSED APPOINTMENTS

In the event that your schedule requires you to reschedule or cancel an appointment with Dr. Goldman, he will be happy to accommodate you with **AT LEAST 48 HOURS NOTICE.** When you make an appointment with a therapist, you are paying not only for his/her services but also for his/her time. As a one-time courtesy, you will not be charged for the first missed appointment or late cancellation. You will be charged a no-show fee for subsequent missed appointments ($80/hour; $40/half-hour) or late cancellations ($40 for all appointments). If you use health insurance benefits for your therapy, be advised that health insurance companies (including Medicare) cannot be legally billed for missed appointments. As such, you will be solely responsible for the fee for missed sessions.

*** Initial _____**

INSURANCE AND RELEASE OF INFORMATION

If you are using insurance, your contract with your health insurance company requires that Dr. Goldman provide certain information relevant to the services you receive. Dr. Goldman is required to provide a clinical diagnosis and sometimes additional clinical information such as treatment plans, summaries, or sometimes copies of your complete medical record. We will make an effort to release only the minimum information about you that is necessary for the purpose requested. By signing this agreement, you agree that we may provide requested information to your carrier. You always have the right to pay the full fee for our services to avoid the disclosure of any information to your insurance company (unless prohibited by your insurance contract).

*** Initial _____**

LEGAL MATTERS

If Dr. Goldman is subpoenaed or court-ordered to provide testimony or records (either by you or by another party) in a legal matter you are involved in, you are responsible for payment for time spent preparing for legal matters; travelling to/from legal settings; waiting to be called into legal settings; and in legal settings. His charge is **$300.00 per hour** for preparation and attendance at legal proceedings. A predetermined block of time will be set aside for the day of the legal proceedings. Payment for the time block is required 10 days in advance; must be paid in the form of a credit card or cashier's check; and no partial or full refunds will be given for paid time that goes unused.

*** Initial _____**

CONSENT TO TREATMENT

I consent to mental health services. I authorize Peace River Psychology Center to bill my medical insurance and to release any information necessary to file a claim in order for them to be paid for their services. I consent that Peace River Psychology Center may receive payment from my insurance company for any services they render to me and I agree to pay for any amounts not paid by my insurance, including the fees stated above for no-shows and cancellations occurring with less than 48 hours notice. I understand that I have the right to refuse or terminate treatment at any time.

My initials above and my signature below certify that I have read and understand the information in this document, that I accept all specified terms and fees therein, that I have received answers to any questions I may have, and that I have received information on patient rights and the Health Insurance Portability and Accountability Act.

_____ _____

Patient Signature Date

_____ _____

Legal Guardian if patient is a minor Date

* You may revoke this agreement in writing at any time. Such revocation will be binding unless (a) our office staff have taken action in reliance on it; (b) there are obligations imposed on us by your health insurer in order to process or substantiate claims made under your policy; or (c) you have not satisfied any financial obligations you have incurred.