

**BEHAVIORAL
HEALTHCARE
CONSULTANTS**

OFFICE POLICY STATEMENT

Welcome to Behavioral Healthcare Consultants. We appreciate your trust and the opportunity to be of help to you. We ask that you read and sign this office policy statement in order to indicate your understanding of our office procedures and consent to receive treatment services within these guidelines.

CONFIDENTIALITY OF RECORDS:

All written and spoken information related to psychological services is held in strictest confidence. Information will not be provided to any third party without written authorization from you except where legal exceptions to the general rule of confidentiality apply. The legal exceptions involve information regarding suspected child abuse, potential harm to oneself or others, and instances where the court may subpoena records. If you want to have information released to a third party (attorney, insurance company, etc.), you or they should request release of information in writing, authorized by your signature. Since the assimilation and organization of pertinent information takes therapist and/or staff time, we reserve the right to charge an appropriate fee for such services. If your therapist feels that it will be useful to discuss your progress or situation with another person, you will be asked for permission and to sign a Release of Information form. Notice of how medical information about you may be used and disclosed and how you can get access to this information is disclosed within our HIPAA "Notice of Privacy Practices". Please review this information carefully and discuss any concerns that you may have about this information with your therapist.

APPOINTMENTS:

All outpatient professional services are provided by appointment except in cases of unusual urgency. Although length of sessions can vary depending on treatment needs, appointments are typically 45 to 50 minutes. Psychological and neuropsychological testing procedures generally require several hours and will be scheduled accordingly. Appointments can be made by contacting the Lancaster office at (717) 581-5255 from 8:00 a.m. to 7:00 p.m. Monday through Thursday and 8:00 a.m. to 4:00 p.m. on Friday. Both day time and evening appointments may be scheduled. For emergency services, we may be contacted through our 24 hour answering service by dialing (717) 581-5255 and following the prompts to be connected. Our service may also be contacted directly at (717) 396-9601. Out of Lancaster County call toll free at (800) 535-4803.

EMERGENCIES:

For life threatening circumstances dial 911. Notify your Therapist by telephoning our office at (717) 581-5255 and follow the prompts to speak to our receptionist or after hours transfer to our 24 hour answering service. If you cannot reach your Therapist or another BHC Therapist, call your physician/psychiatrist or go to a hospital emergency room. Alternative support services including referral services through Crisis Intervention Units are available in **Lancaster County** at (717) 394-2631, **York County** at (800) 673-2496, **Dauphin County** at (717) 232-7511, **Cumberland County** at (717) 763-2222 and **Hanover/Adams County** at (717) 632-4900.

CANCELLATIONS AND MISSED APPOINTMENTS:

Your appointment time has been reserved exclusively for you. If you are unable to keep a scheduled appointment, please notify us at least 24 hours in advance so that the time can be used

client initials _____

for other clients. If a timely cancellation has not been made, you will be billed for one half of the fee for the service. If you fail to appear for your appointment without prior notice of any kind, you will be billed the full fee for the scheduled time.

FEES:

Our fees are established as an hourly or per session rate and all services are billed on the basis of time. This includes diagnostic interviewing and testing, psychotherapy, preparation of letters and reports, consultations, and travel time for off-site services. In the event that you experience significant financial difficulties and have difficulties with payment of your bill, please discuss your circumstances with your therapist.

BILLING AND FINANCIAL RESPONSIBILITY:

We are committed to providing you with the best possible care. Your understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibilities.

For Managed Healthcare and Contractual Payors: Co-payment is expected at time of service. At each appointment, you will receive a copy of a superbill containing information regarding your session. We will bill your managed health care plan or health insurance plan and follow the contractual obligations that exist between your plan and Behavioral Healthcare Consultants. Clients have the obligation to be aware of the provisions of their health insurance and their requirements to obtain benefits. Clients are usually responsible for non-covered services.

For self-pay or those with non-participating insurance plans: Full payment is expected at time of service. At each appointment, you will receive a copy of a superbill containing information regarding your session. If applicable, you can use this form to obtain reimbursement from your insurance plan. Please remember that insurance is a contract between you and your insurance carrier. Therefore, you are responsible for all charges incurred, establishing your insurance coverage, and corresponding with your carrier to obtain reimbursement.

OVERDUE ACCOUNTS:

Because outstanding accounts represent a form of interest-free loan, our policy is to charge a **billing fee** of \$2.00 per \$100 of balance owing (or fraction thereof) per month for which we have not received payment for 30 days. In addition, unpaid balances owed by you that remain outstanding in excess of 60 days may be assigned to an outside collection agency. When accounts are placed with an outside collection agency a **collection fee** of 35% of the balance owing will be added to your outstanding balance.

Please feel free to ask any questions you may have regarding the above policies before signing below. Your signature indicates that you have read the Office Policy Statement and agree to the above stated conditions.

I have read and understand this policy and agree to abide by it accordingly.

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Signature (client/parent/legal guardian)

Date