

Boston Evening Therapy Associates, LLC  
7 Kent Street Brookline, MA 02445  
(617) 738-1480  
www.bostoneveningtherapy.com  
info@bostoneveningtherapy.com

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Social Security Number: \_\_\_\_\_  Male  Female

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Other phone: \_\_\_\_\_

Email address: \_\_\_\_\_

Preferred means of Communication:  Cell  Call Work  Call Home  Email

Primary Care Physician: \_\_\_\_\_ Office Phone: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship: \_\_\_\_\_

Insurance Primary Insurance Company: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Name of Insured if Different from Client: \_\_\_\_\_ DOB: \_\_\_\_\_

Insurance ID # \_\_\_\_\_ Group # \_\_\_\_\_

Secondary Insurance Company: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Name of Insured if Different from Client: \_\_\_\_\_ DOB: \_\_\_\_\_

Insurance ID # \_\_\_\_\_ Group # \_\_\_\_\_

Insurance Coverage Information Annual Deductible: \_\_\_\_\_

Insurance Coverage Per Session 100% 80% 50% Other: \_\_\_\_\_

How much coverage per calendar year? \$ \_\_\_\_\_ or sessions \_\_\_\_\_

Co-Payment per Session: \$ \_\_\_\_\_ Other: \_\_\_\_\_

### **Release of Information to Insurance Company**

I authorize the use of disclosure of my individually identifiable health insurance information necessary to process insurance claims. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or healthcare provider, the released information may no longer be protected by federal privacy regulations.

### **Notice of Privacy Practices and Informed Consent**

The following information provides an overview of the services I provide as a Licensed Mental Health Clinician and serves as an agreement between myself (the provider) and you (the client). Please read the following points carefully and make notes or questions you have for our next session. Periodically, we may review this agreement at any time as the therapeutic process deepens.

### **Services**

Counseling is a relational process that requires the participation of you, the client, and myself as a mental health professional. My approach to our work together is based on my clinical training as well as your immediate concerns and needs (including your spiritual and religious orientation if you choose). My intent is to help you to strengthen your relationship with yourself and others, as well as to help you address a variety of life's challenges.

### **Risks of Counseling**

Counseling requires a commitment of the both of us. At times, the process of therapy can often surface difficult emotions and memories; including fear, anger, sadness, and grief. These feelings are healthy and can lead to greater understanding and freedom to express our true selves and to live a life of purpose and meaning. In the event that these feelings become too difficult to manage, I am available by phone and, depending on your particular circumstances, will be available for additional face-to-face sessions.

### **Contact Information**

I am available by telephone at \_\_\_\_\_ if you need to contact me. I generally check for messages each weekday and usually return calls as soon as possible, If I am unavailable for an extended time, I will leave a message on my answering machine, if we are currently working together I will inform you personally. In an emergency please dial 911 and go to the nearest hospital emergency room. I also communicate via email and text messaging to set up appointments only. I will not discuss your treatment via email or text messaging to protect your privacy and rights.

### **Confidentiality**

Our sessions together will be kept between you and me. Legally, I am unable to discuss our sessions with anyone with the following exceptions:

- 1) You are planning to hurt yourself or someone else. These actions may include: My notifying a potential victim, contacting the police, or seeking hospitalization for my client.
- 2) I am mandated by a court of law to testify regarding a child custody dispute or a case in which your mental health is at issue.
- 3) I am able to speak with someone at your request only after you sign a release.

### Sessions

During the first two sessions, I will evaluate your current counseling needs so that we can assess if I am the best professional to meet your clinical needs. If we decide that your needs cannot be met through my practice, I will be happy to refer you to another mental health clinician who may best fit your therapeutic needs. Our sessions will last 50 minutes.

### Professional Fees, Cancellation Policy and other Charges

If not covered by your insurance, my hourly fee is \$130.00 for a 50-minute session. Payments are required at the beginning of each session. Missed appointments are not covered by any insurance. If you miss an appointment or do not cancel within 24 hours prior to the session, a full session charge of \$130.00 will apply to be paid at your next scheduled appointment or will be charged to your card if you have chosen to use a credit card. You are responsible to verify your coverage with your insurance prior to beginning therapy and agree to pay for any costs not covered by your insurance including co-payments, unmet deductibles and/or unauthorized sessions.

### Insurance Coverage and Private Pay Fees

I accept certain health insurances as well as private payment for therapy. If we determine that your insurance is one of those which I accept, you must then be able to answer the following questions:

1. Do you have a deductible which must be met before services are paid for by your insurance?

\_\_\_\_\_

2. How much is the deductible?

\$ \_\_\_\_\_

3. Do you have a co-payment and how much is it?

\_\_\_\_\_

4. Is the insurance under your name? \_\_\_\_\_ If not, what is the name and birth date of the card holder?

\_\_\_\_\_

5. Does your insurance require a pre-authorization for visits? \_\_\_\_\_ If so, have you called to attain this?

6. Does your insurance limit the number of visits you can have in a calendar year? \_\_\_\_\_ If yes, what is the number limit?

### **Professional Records**

The laws and standards of my profession require that I keep treatment records. You are entitled to request a copy of your records upon a 48-hour advance written notice. I recommend that upon review of your records that we do so together so that I can be available to answer any questions you may have.

**Agreement**

Your signature below indicates that you have read and agree to abide by the terms of our professional relationship. I agree that I have read and understand the contents of the "Notice of Privacy Practices and Inform Consent" and agree to the terms and conditions. Please retain your copy of "Therapy Agreement/Relevant Information" for your reference.

**Signature:**

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**Client, or parent/guardian of minor child** **Date**

**Signature:**

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**Client, or parent/guardian of minor child** **Date**

**Printed Name:**

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**Mental Health Clinician's Signature** **Date**

**Authorization to Use Credit Card for Psychotherapy Services**

I authorize Boston Evening Therapy Associates, LLC (BETA) to charge my credit card for the sole purpose of psychotherapy, consulting or counseling services rendered.

I authorize BETA to use my credit card exclusively for costs incurred or outstanding as a result of psychotherapy including, insurance copayments, unmet insurance deductibles, missed or late cancellations of appointments.

Missed Appointments with less than 24 hrs notice in the amount of: \$130

Patient Name (please print)

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Patient's Address with Zip Code

---

Credit Card:  VISA  MASTERCARD  AMERICAN EXPRESS

Credit Cd#:

---

Exp. date:

---

3 digit code

---

Cardholder's Name (Please Print)

---

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

Therapist Name (Please Print)

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Signed: \_\_\_\_\_

Date: \_\_\_\_\_