Boston Evening Therapy Associates, LLC
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1180 Beacon Street, Brookline, MA 02446
(617) 738-1480
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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:** _____
Who Referred you to Boston Evening Therapy: _____

Emergency Contact: _____ **Phone:** _____
Relationship: _____

Primary Insurance Company: _____
Insurance ID #_____ **Group #** _____
Address: _____
City/State/Zip: _____
Phone: _____

Insurance Coverage Annual Deductible: _____ **Co-pay per session:** _____
Insurance Coverage Per Session 100% 80% 50% Other: _____

Name of Insured if Different from Client: _____ **DOB:** _____

Secondary Insurance Company: _____
Insurance ID#: _____ **Group#:** _____
Address: _____
City/State/Zip: _____
Phone: _____

Name of Insured if Different from Client: _____ **DOB:** _____
Insurance Coverage Annual Deductible: _____ **Co-pay per session:** _____
Insurance Coverage Per Session 100% 80% 50% Other: _____

How much coverage per calendar year? $_____**or sessions** _____

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, our hourly fee is $155.00 for a 45-50 minute session. Payments are required at the beginning of each session. Missed appointments are not covered by any insurance. In addition, missed appointments with less than 24 hours notice will be charged up to $155.00. It will be paid at your next scheduled appointment or will be charged to your card if you have chosen to use a credit card. If your payment is returned by the bank, you agree to pay any bank fees in addition to the original payment. You are responsible to verify your coverage with your insurance company 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. If you coverage changes during time with us, you are responsible to let your clinician know about the change, or you will be responsible for costs not paid by your insurance

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? _____ If so, how much is the deductible? $_____

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

3. Is the insurance under your name? _____
   If not, what is the name and birth date of the card holder?_____

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

5. 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

My signature below indicates that I 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 “Patient Demographics and Therapy Agreement” for your reference.

Signature: _____ _____
Client, or parent/guardian of minor child Date

Signature: _____ _____
Client, or parent/guardian of minor child Date

Printed Name: _____

Signature: _____ _____
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: up to $155

Amount to be charged: $_____

Patient Name (please print) _____

Patient's Zip Code _____

Credit Card: ☐ VISA ☐ MASTERCARD ☐ AMERICAN EXPRESS

Credit Cd#: _____

Exp. date: _____

3 or 4 digit code _____

_____

Cardholder's Name (Please Print): _____

Signed: _____ Date: _____

Therapist Name (Please Print): _____

Signed: _____ Date: _____