Boston Evening Therapy Associates, LLC
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1180 Beacon
Street, Brookline, MA 02446
(617) 738-1480
www.bostoneveningtherapy.com
info@bostoneveningtherapy.com

Today's Date: _____

Name: _____ Date of Birth: _____
☐ Male ☐ Female ☐ Transgender
Social Security Number: _____

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: _____
Name of Insured if Different from Client: _____ DOB: _____
Insurance ID #_____ Group # _____
Address: _____
City/State/Zip: _____
Phone: _____

Secondary Insurance Company: _____
Name of Insured if Different from Client: _____ DOB: _____
Insurance ID#: _____ Group#: _____

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:

Deductibles:

1. Do you have a deductible which must be met before services are paid for by your insurance?
   ___ Yes ___ No
   If so, are Behavioral Health visits included in this deductible? ___ Yes ___ No
   How much is the deductible? $_____

   After the deductible is met, do you have a:
   Copay: ___ Yes ___ No
   If yes, how much? $_____
   Co-Insurance: ___ Yes ___ No
   If yes, how much? $_____
   Or are visits covered at 100%? ___ Yes ___ No

2. If you do not have a deductible, do you have a co-payment and how much is it?
   ___ Yes ___ No $ _____

3. Is the insurance under your name? ___ Yes ___ No
   If not, what is the name and birth date of the card holder? _____

4. Does your insurance require you to call for pre-authorization for visits? ___ Yes ___ No
   If so, have you called to attain this? _____

5. Does your insurance require the therapist to request pre-authorization before your first visit, or authorization after _____ visits?
   ___ Yes ___ No

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

7. Do you have out-of-network benefits if BETA does not accept your insurance?
   ___ Yes ___ No

Notice of Privacy Practices, Informed Consent and Therapy Agreement

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 provided to you by BETA as a Psychologist, Licensed Independent Clinical Social Worker, or Licensed Mental Health Clinician and serves as an agreement between the provider and you (the client). Please read the following points carefully and make notes or questions you have for our next session. Periodically you may review this agreement with your mental health professional at any time as the therapeutic process deepens.

Services

Counseling is a relational process that requires the participation of you (the client) and your mental health professional. The work together is based on clinical training as well as your immediate concerns and needs (including your spiritual and religious orientation, if you choose). Our 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 by yourself and your mental health professional. 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, please inform your mental health professional and, depending on your particular circumstances, additional face-to-face sessions will be scheduled.

Contact Information

Your mental health professional is available by telephone (phone number is on their business card), if needed. Messages are generally checked each weekday and usually returned as soon as possible. If unavailable for an extended time, a message stating this will be on the answering machine. If you are currently working with one of our professionals, they will inform you personally. In an emergency, please dial 911 and go to the nearest hospital emergency room. We also communicate via email and text messaging to set up appointments only. We will not discuss your treatment via email or text messaging to protect your privacy and rights.

Confidentiality

All sessions will be kept between you (the client) and your mental health professional. Legally, we are 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: Your mental health professional notifying a potential victim, contacting the police, or seeking hospitalization for you, the 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, we will evaluate your current counseling needs so that we can assess if you have been paired with best professional to meet your clinical needs. If we decide that your needs cannot be met through the first mental health professional you meet with, that mental health professional will be happy to refer you to another mental health professional who may best fit your therapeutic needs. Our sessions will last 45-50 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. **If you miss an appointment or do not cancel within 24 hours prior to the session, a full session charge of $155.00 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.** 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 your 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.

Professional Records

The laws and standards of our profession require that mental health professionals keep treatment records. You are entitled to request a copy of your records upon a 48-hour advance written notice. Boston Evening Therapy recommends that upon review of your records that you do so together with your mental health professional so that they are 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 Informed Consent" and agree to the terms and conditions.

Please retain your copy of “Notice of Privacy Practices and Informed Consent” 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 or HSA card exclusively for costs incurred or outstanding as a result of psychotherapy including the following: insurance copayments, unmet insurance deductibles, missed or late cancellations of appointments.

Missed Appointments with less than 24 hrs notice in the amount of: $155

Amount to be charged: $_____

Patient Name (please print) _____

Patient's Zip Code where you receive your credit card statement _____

Credit Card: ☐ VISA ☐ MASTERCARD ☐ AMERICAN EXPRESS

Credit Cd#: _____

Exp. date: _____

3 digit code _____

_____

Cardholder's Name (Please Print): _____

Signed: _____ Date: _____

Therapist Name (Please Print): _____

Signed: _____ Date: _____