NEW PATIENT INFORMATION
CONSENT AND AGREEMENT

PSYCHOLOGICAL SERVICES. Psychological services vary depending on the reason for referral. In most cases, the initial appointment is set up with the parents/guardians of the child and it is spent gathering background information and relevant information regarding the current concerns or difficulties. After sufficient information is gathered, the next appointment is scheduled with the child. All therapy provided is based on empirically-validated and/or well researched methods and determined based on the presenting problem. Art and play may be integrated into therapy depending on the age of the child. If you have any questions about the procedures, please discuss them as they arise. Often times, therapy requires active participation and there may be times when work outside of the therapy session is recommended to ensure that improvements in behavior will be seen in the home and school environments. Openness and honesty are recommended to ensure that I have as much information as possible to help you and/or your child.

SESSIONS. The initial diagnostic interview typically lasts from 45 minutes to one hour depending on scheduling and availability. Recurrent psychotherapy sessions last approximately 45 to 60 minutes. Weekly appointments are recommended in most cases, but every other week sessions can be scheduled depending on the situation or need of the client. Once an appointment is scheduled, you will be expected to pay for the entire session unless you provide a 24-hour advance notice of cancellation. It is important to note that most insurance companies will not reimburse me for a missed or canceled appointment, so the full $150 fee will be your responsibility. For clients participating in psychological testing with this office, you will be charged $150 for cancellation without 24-hour notice, as typically your evaluation session covers numerous billing hours (sometimes my entire day in the office) and that time cannot be re-scheduled quickly. Since your appointment time is reserved for you, please notify me as soon as possible if you will be unable to attend the appointment. You may leave a message on my voicemail after hours or on weekends if you need to cancel an appointment.

PROFESSIONAL FEES. My hourly fee is $150.00 for psychotherapy and assessment. The fee for the initial diagnostic session is $175. Charges for consultation outside of the therapy session (i.e., school observations, hospital visits, depositions, etc.) will be determined on an individual basis. Fees should be paid at the end of every session. If you are unable to pay for a session and/or have an exceptional circumstance, this should be discussed at the beginning of the session. Cash, check, and most credit cards are accepted for your convenience. Any balances unpaid after 60 days are subject to a 1.5% per month finance charge.

INSURANCE. If you choose to use insurance, preauthorization is often required. It is your responsibility to contact your insurance company to determine your outpatient mental health benefits. If I am not on the panel for your insurance company, it is possible they will reimburse you for a percentage of the fee for “out-of-network” providers. I will not file out-of-network claims on your behalf, but a detailed receipt is available to help

you submit insurance claims. If you are a member of a managed care company in which I participate, I will file insurance for you. I certify that all information given is true and correct and that I have no other coverage applicable to these services. After verification of your insurance eligibility and level of benefits, I will gladly accept only the co-payment. Until that time, please plan on paying the full contracted amount. Regarding insurance, it is important to note that the amount collected is based on information provided from your insurance company and it is common for insurance companies to deny coverage at a later date. For that reason, you may receive a bill for services after a session because your insurance company does not reimburse as anticipated or requests a refund for previously paid services. Please also note that insurance companies often may authorize a certain number of sessions per year. You will be responsible for keeping track of the number of sessions utilized and you must notify me when we approach the end of these authorized sessions. If notified in a timely manner, I am more than happy to submit paperwork for additional sessions if needed. However, I cannot guarantee the authorization of these sessions.

THERAPIST CONTACT. Due to client appointments, I am not always immediately available by telephone. When unavailable, my telephone is answered by the office manager who can take a message for me or direct you to my voicemail. I will make every effort to return your phone call the same business day or when I return to the office the following day, with the exception of weekends or holidays. If you are difficult to reach by phone, please leave me the best times when you will be available. If you are unable to reach me and feel the matter cannot wait for me return your call, please call your physician and/or go to the nearest emergency room and ask for the psychologist on call. When I will be away for an extended period, I will check messages as frequently as possible and return messages once I return to the office. After making initial contact, I can offer my email address if it is determined that this will be the best mode of communication. However, it is important to note that confidentiality cannot be ensured over the internet. Every effort will be made to keep your information confidential, but communicating via email has some disadvantages. If this is the case, for your own protection, please do not include any private identifying information in any of your emails.

LIMITS OF CONFIDENTIALITY. All communication between a psychologist and a patient will remain confidential as provided by North Carolina law. This privilege can be waived by the patient under normal circumstances. However, there are three exceptions to the law, and under these circumstances, a psychologist ethically and legally would need to break confidentiality: (1) the patient is imminently dangerous to him or herself, (2) the patient is imminently dangerous to others and/or has made specific threats to harm an identifiable third person, and (3) actual or suspected incidents of child abuse. If any of the above situations arise, I will make every effort to discuss this with you first before taking the appropriate and necessary actions, and I will limit my disclosure to what is only absolutely necessary. Children and adolescents will have the same confidentiality as adults, with one exception. Parents and guardians will be made aware of their child's progress in non-specific terms, but they will not be informed of specific details of what is discussed in therapy. However, this psychologist will inform parents of any serious health

or safety issues of which their child may be at risk, with the understanding that this determination will be made by the psychologist.

CONSENT FOR SERVICES. I understand that I have the right to consent or refuse treatment. I hereby authorize and voluntarily consent for Dr. Eric Hartman to provide psychological services considered reasonably necessary for myself and/or my minor child, _____ (DOB____/____/_____).

CONSENT FOR RELEASE OF INFORMATION FOR PAYMENT PURPOSES. I authorize Dr. Eric Hartman to release any medical or psychological information necessary to any representative or agent of any entity that may pay for any part of the expenses incurred in connection with the permitted services (including any insurance company, health maintenance organization, employer, or government or social agency) for the purpose of evaluating or processing claims for payment for services rendered. I also hereby authorize any representative or agent or any entity mentioned above that may pay part of expenses incurred in connection with permitted services to release any documentation to apply for said payment. I acknowledge that this consent is valid until such time as bills related to the permitted services have been paid in full.

CONSENT FOR RELEASE OF INFORMATION TO CARE PROVIDERS. I hereby authorize Dr. Eric Hartman to release any and all information contained in the medical record to the care providers listed below in connection with permitted services for continuity of care. I hereby release Dr. Hartman from any and all liabilities, responsibilities, damages, and claims that might arise from the release of information authorized above. I hereby waive any privilege with respect to records released as authorized above. I further understand that I can withdraw this consent for release of information at any time by contacting Dr. Hartman except to the extent that action has been taken in reliance thereon. Provider Names _____, _____, _____.

ASSIGNMENT OF MEDICAID BENEFITS, PATIENT CERTIFICATION, AND PAYMENT REQUEST. I hereby certify that the information given by me in applying for payment under Title XVIII and XIX of the Social Security Act is correct. I request that payment of authorized benefits be made and assign the benefits payable for the permitted services to Dr. Eric Hartman. I am responsible for and agree to pay charges not covered by this agreement including any Medicare deductibles and/or co-insurance.

FOR CLIENTS PARTICPATING IN PSYCHOLOGICAL TESTING. With some insurance companies I have to request authorization for psychological testing. At times, some insurance companies do not authorize the needed number of hours for a comprehensive evaluation or deem some of the testing to not be medically necessary. You will be responsible for those charges not covered by insurance, if we agree to move forward with testing in those areas that are not considered to be covered by your insurance plan. Following completion of the testing day(s), it is your responsibility to contact me for a follow up, feedback appointment where we will review results from

testing and talk about recommendations. The written report will not be completed until payment has been made in full for all services rendered. I am happy to provide verbal feedback of scores and results prior to your balance being paid and completion of the written report.

GUARANTOR AGREEMENT. For and in consideration of the professional services rendered by Dr. Eric Hartman, I hereby guarantee payment of all fees and charges incurred by said patient for permitted services. I accept personal responsibility for paying in full any balance that may remain after my insurance has processed the claims, including those that may be determined as "not medically necessary" by my insurance carrier.

CERTIFICATION AND SIGNATURE. I certify that I have received a copy of my HIPAA rights, have read and understand this consent to services, agree to all financial terms and have signed this consent in the capacity indicated below as of the date indicated below:

___ As an independent (adult) consenting for myself.
___ As a parent (whether adult or minor) consenting for his or her minor child.
___ As a guardian consenting for his or her ward.
___ As a person temporarily standing in loco parentis consenting for the minor under his or her care.

_____
Name (print full name)

_____ _____
Patient or Parent/Guardian Signature Date

Patient Information:

NAME:_____
First Middle Last
ADDRESS:_____
Street City State Zip
PHONE:_____ _____ _____
Home Work Cell
SOCIAL SECURITY#:_____

ASSIGNED SEX: Male____ Female____ GENDER IDENTITY: _____

MARITAL STATUS:_____DATE OF BIRTH:_____AGE:_____

EMPLOYER:_____ POSITION:_____

Can a message be left at Home? ___Yes ___No; Work? ___Yes __No; Cell? ___ Yes ____ No

REFERRED BY:_____ May I contact this person?___Yes ___ No

Have you been in therapy before? __Yes __No For your current problem?___Yes ___ No

If so, Where?_____When?_____

Next of Kin not living with you/Emergency contact:_____

Phone #:_____ Address: _____

_____

Responsible Party/Parent/Self Information:

Name:_____ Date of Birth:_____ SS #: _____

Phone:_____ _____ _____
Work Home Cell

Primary Insurance:

Name of Carrier:_____

Name of Insured:_____ Phone #:_____

ID#:_____ Group #: _____

Release of Authorization/Assignment of Benefits:

I authorize the release of any medical/psychological information necessary to process my insurance claims. I authorize and request payment of medical benefits directly to Dr. Eric Hartman for services rendered. I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the patient. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for charges not covered by this assignment.

Signed: _____ Date:_____