DSM Associates
Psychology Group

CONDITIONS AND CONSENT FOR SERVICES

Name:_____ DOB: _____

I, _____, the undersigned, hereby attest that I have voluntarily entered into services, or given my consent for the minor or person under my legal guardianship mentioned above, at DSM Assoc. Psychology Group, hereby referred to as DSM.

Confidentiality

I am aware that information about my treatment or services is considered confidential and will be used in a manner consistent with proper professional conduct and will only be released to outside sources under applicable state and federal statutes and as detailed in DSM's Notice of Privacy Policies statement. Releases of information may occur without my written consent only in cases of medical emergency; if I (or a person under my legal guardianship) present a threat of harm to myself or others; when child/adult abuse is suspected; or by audit or court order. Information may also be disclosed in consultations with other professionals within DSM in order to provide the best possible treatment. Identifying information will not be used.

Fees for Services

DSM Associates charges the following rates:

$ 220 for the initial intake/consultation session
$ 170 per 45-50 minute therapy session
$ 220 per 60 minute therapy session
$ 220 per hour of psychological testing (includes scoring tests, report-writing, and feedback)
$ 100 per hour of preparation, research, or documentation for court purposes
$ 200 per hour for depositions or court appearances, portal to portal

I understand the fees for services and that payment is required at the time of service unless a third-party payer or insurance company will be billed. I authorize payment directly to my psychologist for insurance benefits to which my provider is entitled under my insurance plan. Payment methods include check, cash, Visa, or MasterCard.

I understand that a specific amount of time is reserved for all appointments and that repeatedly missed appointments or cancellations less than 24 hours prior to the appointment may be charged half of the session fee. Because insurance companies do not pay these fees, I will be responsible for paying the fee prior to the next session. Emergencies will be considered.

I understand that a fee of $25 will be charged for a returned check and that the full payment due must be paid prior to the next session. I understand that if I fail to pay for services received, all billing information, including name, address, place of employment, dates of service, etc. will be used in the process of collection. I further agree to pay all collection costs and reasonable attorney fees.

Consent for Treatment, Consultation, and/or Evaluation and Notice of Privacy Practices

I/We, the undersigned, have reviewed and understand all the preceding statements, will adhere to these policies, and hereby consent to services with DSM Psychology Group. I certify that I have received or been offered the Notice of Privacy Practices and am responsible for reading the contents. I may get more information or clarification if I do not fully understand its contents. I have also been offered or given a copy of this Consent for Treatment form.

Initial
_____

Email Usage

Initial
_____

By initialing to the right, I/we consent for DSM to contact me via email in order to share information about appointments. I understand that if I chose to communicate any information electronically to DSM or my psychologist, there is no guarantee of security or confidentiality with electronically transmitted information and DSM is not liable for any breaches. I also understand that crisis information or need for immediate contact should never be communicated via email.

_____ _____

Client Signature Date

_____ _____

Parent/Legal Guardian Signature Date

_____ _____

Therapist Date

LEGAL GUARDIAN STATEMENT

I attest that I am the current legal custodian of the above-mentioned child under an issued decree or order of a court of competent jurisdiction of my child, and as such, I am fully authorized to consent for consultation, evaluation, and/or treatment with such means that are deemed appropriate.

I understand the other parent may request/review this child's record, unless the non-custodial parent has been legally denied visitation rights or I pursue a court order to stop such review/request. I further understand that it is my responsibility to provide DSM any documentation indicating that the non-custodial parent is not entitled to review this child's records.

I hereby release and agree to indemnify and hold DSM Psychology Group from any and all liability regarding any claim to the contrary.

_____ _____

Parent/Legal Guardian Signature Date

_____ _____

Therapist/Witness Date