Behavioral Health Associates

Psychologist & Patient Agreement

Welcome to Behavioral Health Associates. The following includes some essential information about psychotherapy. Please read and sign at the bottom to indicate that you accept this agreement.

Length and Frequency of Treatment: Psychotherapy typically involves regularly scheduled forty-five minute sessions. Treatment length and session frequency vary depending on your individual needs and our mutually established therapy goals.

Confidentiality: Information you share is kept strictly confidential and will not be disclosed without your written consent. Confidential information for the purpose of treatment, payment and operations. Confidentiality is not guaranteed in life-threatening situations involving yourself or others, or in situations in which children are at risk (such as sexual or physical abuse or neglect). Refer to the document(s) titled "Notice of Privacy Practices" for a thorough explanation of different types of confidentiality associated with health care information and the regulations placed protecting this information.

Patient Rights: There are specific rights that as a patient you retain; the opportunity to: object to the use or disclosure of protected health information; request alternative communication channels; access your protected health information; amend your protected health information; view a record of all disclosures by my practice and complain and/or file reports of privacy violations.

Fee Policy: The fee for an initial diagnostic evaluation is $300.00 and the fee for a 45-50 minute individual therapy session is $250. If you need to cancel an appointment, please notify your therapist at least twenty-four hours in advance; otherwise, you will be charged a fee for the missed session. When you make an appointment you are reserving professional time set-aside specifically for you. If you do not attend or provide sufficient cancellation notice, the time is simply lost. The charge for not showing or for a late cancellation is $75.00. Please be aware that insurance companies will not cover cancellation charges. If you have mental health insurance coverage, we attempt will assist you with insurance reimbursement through the administrative office. In some circumstances insurance may pay only part of the fee. For example, although the fee is $250.00 an insurance carrier may allow for a $90.00 fee. You will be charged for the difference between the ordinary fee and the limit placed by insurance unless otherwise determined by a contractual agreement with your insurance company. This issue is typically clarified on or before our first two sessions. Fees or co-payments are paid at the time of the office visit and balance payments are paid within 30 business days from receipt of invoice.

Phone and Emergency Contact: If you need to contact your therapist by phone, do not hesitate. When not available, please feel free to leave a message on the confidential voicemail for Dr. Bockian at (773) 710-3493 and for Dr. Wallach at (773) 842 2400. We are usually able to return calls within 24 hours. You will not be charged for phone calls unless we have a scheduled conversation or a problem-solving call that lasts more than ten minutes. In case of an emergency of a life and death nature, please go to your local emergency room or dial 911.

Physician Contact: Physical and psychological symptoms often interact. Please inform your therapist of your medical conditions and treatment along with the physician(s) involved. In addition, medication is sometimes helpful for psychological problems. When determined appropriate a referral for medication evaluation or consultation with your primary care physician if (s)he prescribes medication for such issues.

Freedom to Withdraw: You have the right to end therapy at any time. We will provide you with the names of other qualified psychotherapists upon request.

Informed Consent: I have read and understand the above statements. I have had an opportunity to ask questions and I agree to enter into a professional psychotherapy relationship with Behavioral Health Associates.

Patient_____ ***Date***_____