Connecticut Behavioral Health, LLC

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Thank you for making an appointment with me. I will strive to give you the best psychological services available.

RIGHTS

You have the right to be treated with courtesy, respect and dignity. You have the right to ask questions and I encourage you to be an active participant in the planning of the services you will receive.

CONFIDENTIALITY

Confidentiality of information shared between client and myself is maintained at the highest standard in order to foster a positive, trusting, therapeutic relationship. The exceptions to this high level of confidentiality are in the case of suicide, homicide, and/or incest. You need to be aware that health management companies (HMO's) require assessment reports and frequent clinical updates of your problems and progress. For all other requests for information, a release form signed by you is required before information is released.

APPOINTMENTS

I consider an appointment to be an agreement between the two of us. I am responsible to be here and provide psychological services, or inform you otherwise. You are responsible for keeping the appointment or giving me 24 hours notice of cancellation. Should you decide not to keep the appointment without giving the appropriate notice, except in case of an emergency, you will be charged $75.00 for the missed appointment. Telephone calls concerning appointments will be returned as quickly as possible. A therapy session with the client is 45-50 minutes and 10-15 minutes for note taking and therapy planning.

PAYMENT

Payment of services is required at the time of your appointment. Brief telephone calls are not charged. Calls dealing with issues other than appointments will be billed. A psychological evaluation must be paid in full before reports are released. Unless arrangements for payment are made, accounts over 60 days will be charged 1.5% interest per month, while accounts over 90 days will be turned over to a collection agency.

MISCELLANEOUS

The office hours are Monday – Friday, 10:00am to 7:00pm. There is a 24-hour answering service for your convenience. Also for emergencies, please call the number located on your clinician's card.

Please read the following statement and sign and date where indicated.
I _____, give consent for treatment for individual psychotherapy or family therapy per my individualized Treatment Plan discussed with my therapist.

Signature_____Date_____