



# Beech Tree

Consulting &  
Psychological Services

## Patient Information

**Today's Date:**

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### Identification

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Patient Legal Name

Preferred Name

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Date of Birth

Gender

Marital Status

---

Preferred Language

Preferred Pronoun

Employment Status

---

If child or adolescent – Names of parents/legal guardians

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Home Street Address

Apt.

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City

State

Zip

---

Home/Evening Phone

E-mail

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Calls or e-mail will be discreet, but please indicate any restrictions

Would you like appointment reminders? **Yes** **No**

If yes, by which method do you prefer: **Phone** **Text** **E-mail**

### Referral Source

Who referred you to our practice?

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Name

Relationship to You



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## Medical Care

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Clinic/Doctor's Name

Phone

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Address

If you enter into mental health treatment with one of our providers, may your clinician exchange information with your medical doctor so that he or she can be fully informed and we can coordinate your treatment? **(please circle)**    **Yes**        **No**

### Emergency information

Please provide two emergency contacts. We will contact your secondary emergency contact only when/if your primary person cannot be reached. Your emergency contact may be contacted if you experience a medical or mental health emergency in our office. This person may also be contacted if we learn from you via e-mail, phone, tele-communication, or voicemail that you are experiencing a medical or mental emergency outside of the office.

Primary:

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Name

Phone

Relationship

Secondary:

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Name

Phone

Relationship

### Financial Information

We truly appreciate your choosing to come to Beech Tree for psychological services. As part of providing high-quality services, we need to be clear about our financial arrangements. Please see the Services Policy for specific rate and coverage information.

### Health Insurance Information

If you wish to use your commercial health insurance to assist with covering the fees associated with your treatment, please fill in the information below. Provide information regarding your primary insurance only as we do not file secondary insurance.



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## Subscriber Information:

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Name of Subscriber

Date of Birth (subscriber)

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Name of Insurance Company

---

Identification #

Group #

---

Plan #

Effective Date

---

Claims Address

---

Claims Phone

---

Patient Name

Relationship to Subscriber

## Self-Pay Information

If you are choosing to self-pay for your services, please note that payment is due in full at the time of service. We accept most major credit, debit cards, and HSA cards. We are happy to provide you with receipts for your records and/or to obtain HSA reimbursement.

## Payment Information

We accept cash, personal check, or credit/debit/most HSA cards.

We provide the option of keeping a copy of your credit/debit card on file so that payment can be automatically collected at each session. Your credit card information is stored in electronic format as a "token" to increase the security of your information.



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## Authorization to Keep Credit/Debit Card Information on File

By providing the information below, I authorize Beech Tree Consulting and Psychological Services (BTCPS) to store my credit/debit card information electronically in token format. I authorize BTCPS to automatically “run” this card for payment of services at each session. I understand that I will be informed of the amount to be collected each session before the card is charged. I also authorize BTCPS to automatically charge this card for late cancel and no show fees as they are incurred unless I expressly request otherwise on the date of the late cancel or no show appointment. Please see the Services Policy for No Show and Late Cancellation fees.

We do not keep hard copies of your credit/debit card on file. If you would like for us to keep this information on file, please provide your clinician or our administrative assistant with your card and we will save it into the electronic system.

### Authorization:

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Printed Name of Card Holder

Signature authorizing the use of this card

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Address of Card Holder

### For Office Use only:

Information Entered By: \_\_\_\_\_

Date of Entry: \_\_\_\_\_

Assigned Clinician: \_\_\_\_\_



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## Service Policies

A crucial part of the therapeutic process and our therapeutic relationship is open, honest, and clear communication. The purpose of the Service Policies is to maintain a level of clarity in understanding the “nuts and bolts” of the therapeutic relationship. In doing so, we can avoid miscommunication around policy/procedure issues that can interfere with our work. We are happy to address any questions you may have at any time. Please initial each section as indicated acknowledging that you have read, understand, and agree to each policy.

### Scheduling

Most appointments will be considered “standing appointments.” This means that you will be seen on the same day each week and at the same time. In some instances, a variation to this schedule may be arranged as appropriate.

If you need to confirm an appointment, please call our office and our staff will assist you. You may also request to receive appointment reminders by text, call, or e-mail. \_\_\_\_\_ (initial)

### Psychotherapy Session Duration

Our sessions are structured to be between 45 and 55 minutes long. A 30-minute option is available. Use of this option is recommended for brief check-ins should something come up that needs to be processed between your regularly scheduled sessions. A 90-minute session is also available if extended time is needed. Please note that insurance companies will often not cover a 90-minute session, so out of pocket expenses may be incurred if a 90-minute session is held. You and your mental health professional (MHP) will determine the session length that is most appropriate for you. Sometimes your insurance company will dictate the length of session they will cover.

We want to devote as much **focused** time as possible to each of our patients. In doing so, it is very important to sessions start on time and end on time. Your mental health professional (MHP) has approximately 5 to 10 minutes “free” between each patient. During this “free” time, we write a progress note for your session, run to the bathroom, maybe grab a quick snack or drink, return phone calls, check and respond to e-mail, check in with our administrative assistants, and try to clear our mind before the next session. All these things are critical for your MHP so that we can enter the next session and provide as much **focused** time as possible. Given that we only have 5 to 10 minutes to work with between sessions, losing even a minute or two for a session that runs long can prevent your MHP from having that much needed self-care break between sessions.

So...to ensure that your MHP can engage in self-care, just as we encourage you to engage in self-care, please note the following:

- Your mental health professional may use a gentle chime in session. This chime will be set to give us a 7-minute indication that the session time is ending. Once this first chime is heard, it is a good time to wrap up what is being discussed and move toward ending the session. Your MHP will help bring the discussion to a close, review any “homework assignments” for the next session, check the schedule, and collect payment for the session.
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- If there is not enough time left to collect payment, your MHP will request that you make your payment with the administrative assistant before leaving. You also have the option of making your payment in the first minute or so of your session so that you do not feel rushed at the end.

After this 7-minute indication there will be a final chime that lets us know that the session time has come to an end. We ask that you please respect the close of the session and allow your MHP the time for a much-needed self-care break. Your MHP will adhere strictly to these time boundaries so that we can support self-care for all.

Please note that your MHP holds only an agreed upon amount of time for you. If you are scheduled for a 45-minute session (for example: 1:00 to 1:45) but arrive 7 minutes late, your session will still end at 1:45. Your MHP will make every effort to begin sessions on time. Respecting time boundaries and expectations will allow your MHP to stay on time. It can be anticipated that your therapist will run "late" only on rare occasion.

\_\_\_\_\_ (initial)

## Communication Between Sessions

For communication between sessions, your MHP will only use email communication and only for administrative purposes unless we have made another agreement. This means that email exchanges with your MHP should be limited to administrative matters such as setting and changing appointments, billing matters, and other related issues. You should be aware that your MHP cannot guarantee the confidentiality of any information communicated by email. Therefore, your MHP will not discuss any clinical information by email and we prefer that you do not either. *If you chose to include personal or clinical information within your e-mail, please know that you are doing so at your own risk as we cannot guarantee the confidentiality of e-mail exchanges.* Your MHP may not be able to regularly check email. As such, he or she may not be able to respond immediately. E-mail **should not** be used if there is an emergency. If there is a mental health emergency and you cannot reach your MHP by phone, please contact a 24-hour crisis line or visit your closest emergency department. **Recommended crisis lines:** 317-251-7575 (local); 1-800-273-8255 (National); Text HOME to 741741

\_\_\_\_\_ (initial)

## Psychotherapy/Consultation Cancellations

In the event that a psychotherapy session needs to be cancelled, **please give at least 24 hours' notice.** Notice can be given simply by calling our office and letting our office staff know, by leaving a voicemail for your mental health professional, or by sending an e-mail to your MHP. If leaving a message, please state your name and appointment time to be cancelled. If you have a standing appointment, please indicate whether you intend to keep your next regularly scheduled appointment.

It is very important to remember that **if a psychotherapy cancellation occurs with less than 24 hours' notice (aka "Late Cancel")**, a fee of \$50 will be charged to your account. This is a fee that is not covered by insurance and will be due at or prior to your next session. If you have a credit/debit card on file your card will be automatically charged (please refer to Patient Information form for more details).



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If you are unable to pay this fee in full at or before your next session, we will postpone our sessions until the fee can be paid. In the event of emergency or unavoidable circumstance, please speak with your MHP as soon as possible so that you can discuss the missed appointment fee.

\_\_\_\_\_ (initial)

## **Psychotherapy/Consultation “No Show” Policy**

In the event that you fail to arrive to a scheduled psychotherapy appointment with no advance notification, you will be charged a fee of \$100 for the missed appointment. This is a fee that is not covered by insurance and will be due at or prior to your next session. If you have a credit/debit card on file your card will be automatically charged (please refer to Patient Information form for more details). If you are unable to pay this fee in full at or before your next session, we will postpone our sessions until the fee can be paid.

Please be reminded that after two consecutive failed appointments (“No Show”), you will automatically be discharged from treatment. If you would like to continue with treatment, please contact your mental health professional to discuss options. \_\_\_\_\_ (initial)

## **Testing Appointment Cancellations or “No Shows”**

Testing appointments are allocated a significantly longer period of time (often several hours) than psychotherapy sessions. As such, appropriate cancellation of appointments is critically important. If a testing session is not cancelled within 24 hours of the scheduled appointment, a \$200 fee will be applied to the account. If you have a credit/debit card on file your card will be automatically charged (please refer to Patient Information form for more details). No additional testing sessions will be scheduled until this fee is paid in full.

If there is a “No Show” for a scheduled testing session, the \$200 fee will be assessed, and the testing will not be re-scheduled. If you have a credit/debit card on file your card will be automatically charged (please refer to Patient Information form for more details). These fees will not be covered by your health insurance.

\_\_\_\_\_ (initial)

## **Payments**

Payment in full is expected on the date of the provided service. We understand that healthcare expenses can add up quickly and can cause added stress. As such, it is our goal to assist all patients in maintaining their accounts with us so that there is always a zero balance. This requires that all co-pays are made prior to or at each session, late cancel and “No Show” fees are avoided and/or paid promptly, and deductible amounts are paid in full. If you must carry a balance on your account, we will work with you to arrange a payment plan so that your psychotherapy is not interrupted due to financial reasons. Not adhering to the payment plan will result in termination of services.

As a courtesy, we will file insurance claims on your behalf. Due to the complexities of insurance billing, we do not accept secondary insurance and will not file claims for secondary insurances. Likewise, we will submit claims no more than two times for each date of service.



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If a claim is denied after two attempts at filing, you will become responsible for full payment of the amount billed. Please remember that billing through your insurance company does not guarantee that your insurance company will pay for the claim.

Please remember that we also reserve the right to postpone or terminate our work together if you become unable to pay for the services provided or planned. To minimize financial strain on you, your mental health professional and the practice, we will strictly adhere to this policy. Please inform us immediately if you anticipate difficulty paying for your services or if a change in insurance coverage occurs.

You will receive a monthly invoice from Beech Tree Consulting and Psychological Services if your account has a balance. Payment in full is expected within 30 days of the issuance of the invoice. Failure to pay your balance in full within 30 days may result in postponement or termination of services. \_\_\_\_\_ (initial)

### Standard Fees (Doctoral level clinician)

Initial Intake	\$225 (50-55 minutes)
Individual Therapy	\$150 (16-37 minutes); \$175 (38-52 minutes); \$200 (53-55 minutes) \$250 (90 minutes)
Group Therapy	\$50 (55 minutes) \$70 (75 minutes)
Family Therapy	\$175 (38-52 minutes); \$200 (53-55 minutes); \$250 (90 minutes)
Psychological Assessment	\$175/unit or hour
Psychotherapy No Show	\$100
Psychotherapy Late Cancel	\$50
Testing No Show or Late Cancel	\$200

### Standard Fees (Masters level clinician)

Initial Intake	\$125 (50-55 minutes)
Individual Therapy	\$75 (16-37 minutes); \$90(38-52 minutes); \$ 105(53-55 minutes) \$135 (90 minutes)
Group Therapy	\$30 (55 minutes) \$50 (75 minutes)
Family Therapy	\$100 (38-52 minutes); \$115 (53-55 minutes); \$145 (90 minutes)
Psychotherapy No Show	\$100
Psychotherapy Late Cancel	\$50

\*Standard fee for clinicians in training for all services, including No Show and Late Cancel charges, is \$50.

\_\_\_\_\_ (initial)



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## Non-Covered Services

*\*Non-Covered Services* include all services not typically covered by third-party payers (mental health/medical insurance).

Non-Covered Administrative Services                      \$15 per 5 min increments (first 5 minutes free)

These services most often include but are not limited to:

- Consultation with medical, mental health, or academic professionals on your behalf by phone, e-mail, fax, or in person.
- Review of medical records
- Preparation of reports or letters for other providers/legal counsel, etc...
- Completion of documents for disability claims, extended insurance reviews, worker's compensation, etc...
- Duplication of medical records (photocopying fees, notary fee, and postage fees may also apply)

\_\_\_\_\_ (initial)

Non-Covered Mental Health Services (services which are clinically recommended but that may not be covered by your insurance company)

- Standard fees apply. See above. A quote will be provided and agreement for payment of services rendered will be required before services will be provided.

\_\_\_\_\_ (initial)

## Service Limitations

Please be advised that we do not provide legal or forensically-informed therapeutic services. If you require services of this nature, we will provide you with referrals to appropriately qualified mental health professionals. We also will not voluntarily provide letters to attorneys or legal counsel regarding our work together. If you become involved in a legal suit, please inform us immediately so that we can develop an appropriate treatment plan and we can provide you with necessary referrals. \_\_\_\_\_ (initial)



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## Office Hours

We typically have coverage of our phones by an administrative assistant Monday through Thursday 8am to 4pm and Friday 8am to 12noon. Our mental health professionals may keep different office hours. Please consult with your mental health professional regarding their in-office availability.

Please feel free to call at any time and leave a voice-message. We do check messages frequently and will return your call as soon as possible. \_\_\_\_\_ (initial)

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Signature of Client or Legal Guardian

Date

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Printed Name

Relationship to Client

---

Signature of Mental Health Professional

Date



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## Consent to Treatment (Adult)

I do hereby seek and consent to take part in the treatment provided by \_\_\_\_\_, a mental health professional as defined by Indiana law. Treatment may include individual psychotherapy, group psychotherapy, psychological testing, couples therapy, and/or family therapy or a combination of several of these. I understand that developing a treatment plan with this clinician and determining the most appropriate combination of services is critical for effective treatment. I agree to work collaboratively with this clinician to review our work and progress toward meeting treatment goals.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this clinician.

I am aware that I may stop my treatment with this clinician at any time. If I choose to stop treatment, I will still be responsible for paying for the services I have already received.

I understand that I am consenting to only those mental health services that the above named clinician is qualified to provide within the scope of their professional license, certifications and/or training or within the scope of the license certification and training of those mental health professionals directly supervising the care you are receiving.

My signature below shows that I understand and agree with all of these statements.

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Signature of Client (or person acting for client)

Date

---

Printed Name

Relationship to Client

I, \_\_\_\_\_, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me reason to believe that this person is fully competent to give informed and willing consent.

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Signature of Mental Health Professional

Date

\_\_\_\_\_ Copy accepted by client    \_\_\_\_\_ Copy kept by therapist

6411 South East St. Ste A  
Indianapolis, Indiana 46227

317 780 5750 phone  
317 780 5755 fax

beechtreepsych.com



## **Your Information. Your Rights. Our Responsibilities.**

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

**Please review it carefully.**

### **Your Rights**

**When it comes to your health information, you have certain rights.** This section explains your rights and some of our responsibilities to help you.

#### **Get an electronic or paper copy of your medical record**

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

#### **Ask us to correct your medical record**

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

#### **Request confidential communications**

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say “yes” to all reasonable requests.

*continued on next page*

## Your Rights *continued*

### Ask us to limit what we use or share

- You can ask us **not** to use or share certain health information for treatment, payment, or our operations.
  - We are not required to agree to your request, and we may say “no” if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
  - We will say “yes” unless a law requires us to share that information.

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### Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

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### Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

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### Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

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### File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **[www.hhs.gov/ocr/privacy/hipaa/complaints/](http://www.hhs.gov/ocr/privacy/hipaa/complaints/)**.
- We will not retaliate against you for filing a complaint.

## Your Choices

**For certain health information, you can tell us your choices about what we share.** If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

**In these cases, you have both the right and choice to tell us to:**

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory
- Contact you for fundraising efforts

*If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

**In these cases we never share your information unless you give us written permission:**

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

**In the case of fundraising:**

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

## Our Uses and Disclosures

**How do we typically use or share your health information?** We typically use or share your health information in the following ways.

**Treat you**

- We can use your health information and share it with other professionals who are treating you.

**Example:** A doctor treating you for an injury asks another doctor about your overall health condition.

**Run our organization**

- We can use and share your health information to run our practice, improve your care, and contact you when necessary.

**Example:** We use health information about you to manage your treatment and services.

**Bill for your services**

- We can use and share your health information to bill and get payment from health plans or other entities.

**Example:** We give information about you to your health insurance plan so it will pay for your services.

*continued on next page*

**How else can we use or share your health information?** We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html).

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**Help with public health and safety issues**

- We can share health information about you for certain situations such as:
  - Preventing disease
  - Helping with product recalls
  - Reporting adverse reactions to medications
  - Reporting suspected abuse, neglect, or domestic violence
  - Preventing or reducing a serious threat to anyone’s health or safety

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**Do research**

- We can use or share your information for health research.

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**Comply with the law**

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we’re complying with federal privacy law.

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**Respond to organ and tissue donation requests**

- We can share health information about you with organ procurement organizations.

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**Work with a medical examiner or funeral director**

- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

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**Address workers’ compensation, law enforcement, and other government requests**

- We can use or share health information about you:
  - For workers’ compensation claims
  - For law enforcement purposes or with a law enforcement official
  - With health oversight agencies for activities authorized by law
  - For special government functions such as military, national security, and presidential protective services

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**Respond to lawsuits and legal actions**

- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

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*Beech Tree Consulting and Psychological Services requires that a written authorization be signed by you before any of your confidential information is released for the purposes of treatment planning, care coordination, cooperation with legal counsel. Please review Services Policy, Consent to Treatment, and Agreement for Parents for more information about confidentiality and limits of confidentiality.*

## Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html).

### Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

*January 1, 2019*

**This Notice of Privacy Practices applies to the following organizations.**

*Beech Tree Consulting and Psychological Services*

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*Dr. Robbi Crain - - Privacy Officer  
6249 South East Street Suite I  
Indianapolis, IN 46227*



# Beech Tree

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## Consent to Use and Disclose Your Health Information

When we examine, test, diagnose, treat, or refer you, we will be collecting what the law calls “protected health information” (PHI) about you. We need to use this information in our office to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others to arrange payment for your treatment, to help carry out certain business or government functions, or to help provide other treatment to you. By signing this form, you are also agreeing to let us use your PHI and to send it to others for the purposes described above. Your signature below acknowledges that you have read or heard our notice of privacy practices, which explains in more detail what your rights are and how we can use and share your information.

**If you do not sign this form agreeing to our privacy practices, we cannot treat you.** In the future, we may change how we use and share your information, and so we may change our notice of privacy practices. If we do change it, you can get a copy from you therapist.

If you are concerned about your PHI, you have the right to ask us not to use or share some of it for treatment, payment, or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to accept these limitations. However, if we do agree, we promise to do as you asked. After you have signed this consent, you have the right to revoke it by writing to our privacy officer. We will then stop using or sharing your PHI, but we may already have used or shared some of it, and we cannot change that.

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Signature of Client or Personal Representative

Date

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Printed Name of Client or Personal Representative

Relationship to the Client

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Signature of Authorized Representative of this Office or Practice

6411 South East St. Ste A  
Indianapolis, Indiana 46227

317 780 5750 phone  
317 780 5755 fax

beechtreepsych.com



# Beech Tree

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## What You Should Know About Health Insurance and Your Treatment

Your health insurance may pay part of the costs of your treatment. It is important to understand that having health insurance does not guarantee that your services will be paid by the health insurance company. You, not the health insurance company, are ultimately responsible for payment for your services.

### **Confidentiality**

If you use your health insurance to help pay for psychotherapy or psychological testing, you have authorized the insurance company to request from your mental health provider (MHP) information about your diagnosis, the treatment you are receiving, and your progress in treatment. The company may also request progress notes and psychological testing reports. As a contracted provider for your insurance company, your MHP will be obligated to release this requested information to the insurance company if the company requests it. If this information is requested and released to the insurance company all this information will become part of the health insurance company's records, and some of it will be included in your permanent medical record at the Medical Information Bureau, a national data bank that is not open to the public including you. The information will be examined when you apply for life or health insurance, and it may be considered when you apply for employment, credit or loans, a security clearance, or other things in the future. You will have to indicate that you were treated for a psychological condition and release this information, or you may not get the insurance, job, loan, or clearance.

All insurance carriers claim to keep the information they receive confidential, and there are federal laws about its release. The laws and ethics that apply to Mental Health Providers are much stricter than the rules that apply at present to health insurance companies. *There have been reports in the media about many significant and damaging breaches of confidentiality by health insurance companies.* If you are concerned about who might see your records now or in the future, we should discuss this issue more fully before we start treatment and before claims are submitted to your health insurance company. You should evaluate your situation carefully regarding confidentiality.

### **Psychotherapy**

If using health insurance to assist with the costs of psychotherapy, coverage will only occur if you have been diagnosed with a psychiatric disorder. People often seek treatment but do not have a psychiatric disorder. For your health insurance company to cover all or a portion of your treatment, we must also demonstrate that treatment is medically necessary. There are various definitions of medical necessity that vary from company to company. Medical necessity criteria are established by the health insurance company and may not be consistent with what your MHP considers to be medically necessary. If the medical necessity criteria outlined by your insurance company are not met, your insurance company will likely not cover your services. Services can continue, but you will be responsible for paying our standard fees at the time of service.

You must also be aware of how your specific policy works. Some policies have deductibles, co-pays, co-insurances, or a combination of all of these. We encourage you to contact your insurance company prior to coming in for your first appointment so that you understand fully how your



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insurance works. Please be advised that you – not our office staff your mental health professional – are responsible for understanding your individual policy coverage and limitations.

## **Diagnostic Testing**

Diagnostic testing is one of the most beneficial aspects of our work together and something that can only be provided by a licensed clinical psychologist. We use testing to clarify diagnoses, assist in appropriate treatment planning, coordinate care with other medical professionals, and provide information to you or your child's school. With the mounting complexities of health care insurance, comes the risk that your insurance will not cover diagnostic testing.

Often insurance companies have exclusionary clauses stating that they will not cover testing that results in diagnoses of disorders such as, but not limited to, Attention Deficit Hyperactivity Disorder, Autism Spectrum Disorder, and Learning Disorders. As testing is used to identify these and many other disorders, we have experienced an increasing number of denials for payment from insurance companies after testing has already occurred.

Specific medical necessity criteria apply to diagnostic testing. Again, your insurance company determines these criteria, not your mental health provider. As such, there are times when diagnostic testing may not meet medical necessity criteria per the health insurance definition but is highly recommended by your MHP in terms of providing you with the most informed, comprehensive and effective treatment.

In instances where medical necessity criteria are not met, you have the following options:

1. A referral can be provided to another in-network provider who provides testing services. A second opinion can be obtained as to whether medical necessity criteria are met. If this provider determines that medical necessity criteria are indeed met, you may be able to have your psychological testing done through this provider and then return to your MHP at Beech Tree for continued psychotherapy.
2. You have the option to waive the use of your insurance. Diagnostic testing could then be provided by your current MHP or, if your MHP is not a clinical psychologist, a licensed clinical psychologist within the practice. You would be charged a self-pay rate for diagnostic testing. 90-day Payment plans are available if needed. You would be required to sign a waiver indicating that you are voluntarily waiving the use of your health insurance benefit.
  - a. You would be provided with a quote for all testing procedures so that you know exactly what to expect in terms of cost before any diagnostic testing is scheduled.
  - b. The MHP providing testing would be able to determine the exact measures which would be most appropriate for your diagnostic needs with no concern for limits placed upon us by the insurance company.



# Beech Tree

Consulting &  
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## A Few More Things to Consider

We have found that insurance companies often request a copy of the testing report, session notes, and other clinical information long after the claim or claims have been paid. The insurance company reserves the right to request that your MHP pays back any money that they have already received if the company decides later that they will not cover the service. If this happens, you, your MHP, and the practice are all in a financial bind. This would mean that your MHP/the practice must pay back money the insurance company has already paid us. You then become responsible to pay the practice the monies that the insurance company has requested back.

## Our Agreement

I have read and understood the issues described above and willingly enter treatment accepting these limits. I give my therapist permission to submit information to secure payment for the mental health services to be provided to me.

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Signature of Client or Legal Guardian

Printed Name

Date

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Mental Health Professional

Printed Name

Date