BEHAVIORAL HEALTH CLINIC
Outpatient Services Agreement

BEHAVIORAL HEALTH CLINIC is a service of the Psychology Department at Munroe-Meyer Institute for Genetics and Rehabilitation, University of Nebraska Medical Center (UNMC).

CONFIDENTIALITY
Communications between a patient and psychologist/therapist are protected by law. It is generally our practice to consult with your child’s physician regarding our work together, including a written progress note after each visit. Both UNMC and this primary care clinic will maintain records of our work, however, confidentiality is strictly guarded. Written or verbal information regarding your treatment at this clinic is released only to the individuals you identify with your written permission. There may be times when it is necessary for us to talk you on a cell phone or communicate with you through email. We understand that these communications are not secure and therefore will work to use alternative means whenever possible to communicate with you outside of sessions. However, if you do not ever want to be contacted via cell phone or email, please let us know.

There are a few exceptions. In situations involving danger or imminent risk of harm to the patient or to others by the patient, child abuse, or in legal proceedings where emotional condition is an important element and a judge orders my testimony, we may be required to release or disclose information about our work with you/your child. These situations are rare, however, we will make every effort to discuss the matter with you before disclosing such information. In addition, there may be times when the psychologist/therapist may consult with other professionals about your case. If so, the psychologist/therapist will make every effort to avoid revealing any identifying information about you or your family. The consultant is also bound to confidentiality. These consultations will not be discussed with you unless the psychologist/therapist believes it is important to your work together.

TRAINING AND SUPERVISION
The Munroe-Meyer Institute is a training facility dedicated to developing leadership skills in the delivery of pediatric behavioral health services. As part of this training, Post-Doctoral Fellows who have a Ph.D. in psychology will sometimes serve as primary therapists under the supervision of a licensed psychologist. In addition, psychology interns will sometimes be involved with the delivery of services that you receive. In some cases, these students may participate as observers, in some cases, co-therapists, and in some cases as lead therapists, though they will always be supervised directly by a licensed psychologist. The Munroe-Meyer Institute also trains other students who may wish to observe your sessions. You will be informed who would like to observe and when but you may, at any time, request not to be observed.

For your family, __________________ will be assisted by __________________, the supervising psychologist.

TREATMENT APPROACH
BEHAVIORAL HEALTH CLINIC employs an active, practical, brief, and research-supported approach to treatment. We typically conduct an intake evaluation and provide initial recommendations during the first one or two sessions. If we agree to additional sessions, regular attendance by both parent and child is very important. If you are unable, for any reason, to attend regularly we may choose to discontinue treatment. If treatment is ended prematurely, for any reason, we will work with you to find treatment alternatives as needed.

EMERGENCIES
If you have a concern about your child you can contact your clinician during office hours at __________________. If, however, you are experiencing an emergency situation in which someone’s physical safety is threatened, you should call 911 or __________________ immediately.

FEES
Fees are $175.00 per 50 minute session. The initial evaluation which usually includes the clinic visit, records review, scoring and interpretation of behavior ratings, and report preparation is billed at $250.00. Fees are subject to change and some services (e.g., psychological testing, attendance at legal proceedings) may be billed under a different fee schedule. The patient (or the patient’s parent, legal guardian, or authorized representative) retains responsibility for payment of all fees, whether or not they are covered by insurance.

INSURANCE
Many companies require pre-authorization by either the primary care physician or insurance company. It is the patient’s responsibility to see that proper authorization has been received. (If we are listed as a Preferred Provider in your PPO directory, please consult your policy or insurer to determine coverage. Please note that there are different requirements for each company and plan.) We recommend that you contact your insurance carrier before your first visit and ask specifically about your plan’s mental health coverage including number of sessions allowed, types of therapy permitted, and diagnoses not covered by your plan.

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AGREEMENT

FINANCIAL RESPONSIBILITY & ASSIGNMENT OF BENEFITS
I understand that I am responsible for payment for all health care services provided to me at the Behavioral Health Clinic. I hereby assign to UNMC any insurance or other third-party benefits available for health care services provided to me. I understand that UNMC has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to UNMC, I agree to forward to UNMC all health insurance and other third-party payments I receive for services rendered to me immediately upon receipt.

Medicare/Medicaid Benefits
I certify that the information given to apply for Medicare benefits is correct. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration, its intermediaries, or carriers any information needed for this or related Medicare claims. I request that authorized benefits be paid on my behalf.

AUTHORIZATION FOR RELEASE OF INFORMATION
I authorize UNMC to release all treatment information requested by my health insurance carrier, Medicare/Medicaid, or any other third party payors. I authorize UNMC to release all treatment information to my primary care physician. I authorize UNMC to contact my insurance company or health administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information to UNMC.

CONSENT TO TREATMENT
I have read and understood all of the above information and agree to the provisions as described. I have had an opportunity to ask questions about the terms of this agreement. I consent to behavioral health care by BHC staff and acknowledge that no guarantees have been made to me as the result of diagnoses, treatments or evaluations.

NOTICE OF PRIVACY PRACTICES
_____ I acknowledge receipt of the Notice of Privacy Practices by signing below.
_____ Notice of Privacy Practices was provided at previous visit.
_____ Acknowledgement of Notice of Privacy Practices not received
   Reason:
   Describe good faith effort to obtain acknowledgement:

Name of patient ________________________________

Signature ________________________________ Date ____________

Relationship to patient ________________________________

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