Baker Street
Behavioral Health

New Patient Intake

In an effort to keep our records current, we kindly request once you complete this form, PROVIDE US WITH A COPY OF YOUR INSURANCE CARD. Your understanding and cooperation is greatly appreciated.

PATIENT INFORMATION

Name:		Date of Birth:
Pronouns (this helps Baker Street Behavioral Health understand the best way to address you): ☐ She/Her ☐ He/Him ☐ They/Them ☐ I prefer not to say ☐ Prefer to self-describe _____		
Address:		
City:	State:	Zip Code:
Cell #:	Alternate #:	
Email Address:		

INSURANCE INFORMATION

Name of Primary Insured:	Date of Birth:	
Mailing Address (if different from address provided above):		
City:	State:	Zip Code:
Cell #:	Email Address:	
Patient Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Partner ☐ Parent ☐ Other		
Insurance Company:		
Plan ID #:	Group #:	
Address:		
City:	State:	Zip Code:
Phone #:		
Secondary: ☐ Yes ☐ No	Medicare: ☐ Yes ☐ No	Medicaid: ☐ Yes ☐ No

EMERGENCY CONTACT

Name:	Relationship:	
Address:		
City:	State:	Zip Code:
Cell #:	Alternate #:	
Email Address:		

YOU ARE RESPONSIBLE FOR UNDERSTANDING YOUR COVERAGE

Bring your insurance card with you to each office visit. It is your responsibility to be aware of your insurance coverage, including but not limited to policy provisions, deductibles, limitations and authorization requirements. If your plan or insurance coverage changes and/ or you are issued a new card, it is your responsibility to notify us immediately. We are not responsible for charges that are denied because we have relied on information that is not current. In the event a claim is denied, you will be personally responsible for your bill and/or any outstanding charges.

INSURANCE COVERAGE

Baker Street Behavioral Health is an Out of Network provider. As a courtesy, we attempt to verify that your coverage is active and verify your Out of Network, Mental Health benefits before your first appointment with our office. However, you are responsible for finding out all information regarding your out of network coverage prior to your appointment. You are responsible for satisfying the out of network deductible. The deductible is determined by your individual contract with your insurance carrier. Co-insurance fees are your responsibility. Your insurance company expects co-insurance fees to be collected at time of service.

Select insurance companies send reimbursement checks directly to the patient/ insured for services rendered by Baker Street Behavioral Health. Any reimbursement sent directly to the insured for services rendered by our doctors or clinicians must be remitted to Baker Street Behavioral Health within 14 days of receipt. Failure to do so will result in Baker Street Behavioral Health charging the credit card on file the reimbursement amount.

SELF PAYS

All patients without valid insurance or without Out of Network coverage on their insurance policy are considered self-pay patients. All self-pay patients are required to pay at the time service is rendered. Please be prepared to make this payment with the front desk personnel at the start of your visit.

CANCELLATION POLICY

The time we set aside for your appointment is important and affects our efforts to efficiently serve all of our patients. If you are unable to keep your appointment you must provide us with notice at least 24 hours in advance of your appointment. Failure to give the required 24-hour notice will result in you being charged a $75.00 cancellation fee. This fee cannot be billed to your insurance company and will be your direct responsibility. Please call Baker Street Behavioral Health at 201-381-6136 with cancellation.

PAYMENT POLICY

Baker Street Behavioral Health will attempt to verify your Out of Network benefits and submit claims to your insurance carrier directly, as an out-of-network provider. However, it is your responsibility to meet your annual out of network deductible, as well as pay the co-insurance fee at the time of service. All patients without valid insurance or without Out of Network coverage on their insurance policy are considered self-pay patients. All self-pay patients are required to pay at the time service is rendered.

Check Policy:
When you use a check to pay for our services, you authorize us to represent your check to your bank for collection either electronically or by paper draft. In the event your check is returned for any reason, you understand you will be charged for any additional applicable fees as permitted by law.

Credit Card Policy:
Baker Street Behavioral Health requires a credit card on file for the select insurance companies who send the reimbursement checks directly to the patient/insured for services rendered by Baker Street Behavioral Health. Baker Street Behavioral Health requires the insurance reimbursement that is issued by the insurance provider for services rendered by Baker Street Behavioral Health be remitted to our office within 14 days of receipt of the check or the credit card on file will be charged. In addition, Baker Street Behavioral Health reserves the right to charge the credit card on file for any applicable deductible or co-insurance fees or if you are not in compliance with the cancellation policies.

If Your Account Becomes Delinquent:
We will do our very best to work with you. Our billing office may contact you by telephone, email and/or by mail. If you do not respond to our attempts to discuss your balance, we may refer your account to an outside collection agency. Once your account has left our office for collections, we can no longer communicate with you regarding your balance and you must address your circumstances with the agency. You will also be directly responsible for any additional fees associated with the collection of your balance. You should also be aware that referral of your balance to a collection agent may constitute grounds for your discharge from the practice.

If you have any questions regarding our guidelines, please feel free to contact our Billing Department at 201-381-6136.

Your signature below acknowledges that you have read, understood our policies and your responsibility regarding the charges and fees that you have incurred as a result of services that you have received from Baker Street Behavioral Health.

Name of Patient: _____

Name of Patient/Guardian: _____

Signature of Patient/Guardian: _____

Date: _____

Credit Card Information

Name on Card: _____ EXP Date: _____

Credit Card #: _____ CVV: _____

☐ Visa ☐ MasterCard ☐ American Express ☐ Discover Billing Zip Code: _____

FSA Card: ☐ Yes ☐ No SuperBill Needed: ☐ Yes ☐ No

Please initial:

_____ I understand Baker Street Behavioral Health reserves the right to charge my credit card for any applicable deductible or coinsurance fees should payment not be made at the time of the appointment.

_____ I understand Baker Street Behavioral Health reserves the right to charge my credit card if I am not in compliance with the cancellation policy.

_____ I understand as a member of an insurance provider that reimburses the insured rather than the provider rendering the service, Baker Street Behavioral Health reserves the right to charge my credit card the reimbursement payment issued by the insurance provider if the reimbursement check is not brought to Baker Street Behavioral Health within 14 days of receipt of the payment. In the event Baker Street Behavioral Health charges my credit the reimbursement payment, the member can then keep the check issued by the insurance provider.

_____ I understand Baker Street Behavioral Health reserves the right to pass on any applicable chargeback fees permitted by law associated with a disputed credit card charge.

_____ I understand failure to comply with our policies may result in pause in services until my account is made current. Baker Street Behavioral Health, however, reserves the right to terminate services and forward the account to Collections if necessary

Name of Patient: _____ Date: _____

Name of Patient/Guardian: _____

Signature of Patient/Guardian: _____ Date: _____

Baker Street
Behavioral Health

Patient Consent to Treatment

I have read this statement, had sufficient time to be sure that I considered it carefully, asked any questions that I needed to, and understand it. I understand the limits to confidentiality required by law. I consent to the use of a diagnosis in billing, and the release of that information and other information necessary to complete the billing process. I agree to pay the initial evaluation fee and agreed upon session fees. I understand my rights and responsibilities as a patient, and my therapist's responsibilities to me. I agree to undertake therapy with Baker Street Behavioral Health. I know I can end therapy at any time I wish and that I can refuse any requests or suggestions made. I am over the age of eighteen.

Patient: _____ Date: _____

Consent for Treatment of Minors

I/We_____have full custodial guardianship of my child _____. He/she is currently under the age of 18, and I/we consent that he/she may be treated as a patient by Baker Street Behavioral Health.

Parent/Guardian Name: _____

Patient Assent (if over the age of 14): _____ Date: _____

Parents: Do not leave the office while your minor child is with his/her therapist. You must provide a responsible adult who is to be present during your child's visit. It is not the staff's responsibility. In addition, it may be necessary for the therapist to speak with you at some point during your child's session.

Baker Street
Behavioral Health

HIPAA Acknowledgement and Consent Form

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from designated third-party payers.
- Conduct normal health care operations such as quality assessments or evaluations, and physician certifications.

I have been informed by you of your Notice of Privacy containing a more complete description of the uses and disclosures of my health information (available in office in print form). I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at anytime at the address(s) below to obtain a current copy of the Notices of Privacy Practices.

Confidentiality

The practice operates in a “multi-disciplinary” way, meaning that the clinician’s function as a team. Therefore, it is important to understand that the information in the chart is accessible to other clinicians in the office in order to provide you with quality and consistent care. However, no information about you or your care will be released to anyone outside the office without your consent or a court order. The only exceptions include suicidal or homicidal risk factors or child/elder abuse or neglect. You will complete a Release of Information that you can use to list person(s) to whom we may have communications with about you, your care and/or financial matters concerning your account. Children (under the age of 17) have the right to confidential exchanges with clinicians. However, if there are issues that pose grave or immediate danger, these issues may be discussed with parents or legal guardians or child protective services

I understand that I may revoke this consent in writing at any time, except to the extent that the organization has taken action relying on this consent.

Patient’s Name & Date of Birth (MM/DD/YYYY)

Signed (Patient or Legal Representative for Patient)

Date

Baker Street
Behavioral Health

Authorization of Release of Information

I / We _____
Patient Name/Parent or Guardian Name

hereby authorize Baker Street Behavioral Health / _____
Clinician Name

To:

Release information to: Name: _____

Obtain information from: Phone: _____

Exchange information with: Fax: _____

The information requested or authorized for release or exchange pertains to:

Patient Name: _____

Clinical information pertaining to treatment:

Other: _____

This authorization is valid through _____ or indefinitely _____ (initial). I may revoke this authorization by signing, dating, and writing "CANCEL" on this original form or by sending a written, signed and dated request to the clinician/ group above indicating my desire to cancel. I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule. I understand that my treatment provider generally may not condition services upon my signing an authorization unless the services are provided to me for the purpose of creating health information for a third party.

_____ _____
Patient's Signature (if over 14 years old) Date

_____ _____
Parent/ Guardian's Signature Date

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Telehealth Informed Consent for Assessment and Treatment

I, _____, hereby consent to participate in Telehealth with Baker Street Behavioral Health. I understand that Telehealth is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a patient who are located in two different locations.

Electronic systems used will incorporate network and software security protocols and are HIPAA compliant to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

I understand the following with respect to telehealth:

1. I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.
2. I understand that there are risks, benefits, and consequences associated with telehealth, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.
3. I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.
4. I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to telehealth unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).
5. I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telehealth services are not appropriate and a higher level of care is required.
6. I understand that during a telehealth session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to reconnect within ten minutes, please call (201) 381-6136 to discuss possibly having to re-schedule.
7. I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in case of an emergency.

EMERGENCY PROTOCOLS

In case of an emergency your provider will need to know your location. You agree to inform me of the address where you are at the beginning of each session if different than listed below. A contact person who your provider may contact on your behalf in a life- threatening emergency only is also needed. This person will only be contacted in the event of an emergency.

In case of an emergency, my location is: _____

and my emergency contact person's name and phone: _____

EXPECTED BENEFITS OF TELEHEALTH

- Improved access to counseling care by enabling a patient to remain in their home or office.
- More efficient psychological evaluation and management.
- Obtaining expertise of a distant specialist.

POSSIBLE LIMITATIONS OF TELEHEALTH

These limitations include, but may not be limited to:

- Potential misunderstandings arising from the lack of visual cues and voice intonations when communicating electronically.
- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the provider and consultant(s);
- Delays in evaluation and treatment could occur due to deficiencies or failures of the equipment;
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information;
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgmental errors

I have read the information provided above and discussed it with my provider. I understand the information contained in this form and all of my questions have been answered to my satisfaction. I hereby give my informed consent with Baker Street Behavioral Health to use telepsychiatry and teletherapy in the course of my diagnosis and treatment.

Signature of patient/parent/legal guardian

Date

Baker Street
Behavioral Health

Psychotherapy Information Disclosure Statement

As a Baker Street Behavioral Health clinician, I welcome you to our practice. This document contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides new privacy protections and new patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that you be provided with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this information by the end of the first session. Although these documents are long and sometimes complex, it is very important that you read them carefully before our next session. We can discuss any questions you have about the procedures at that time. When you sign this document, it will also represent an agreement between us.

Therapy is a relationship that works in part because of clearly defined rights and responsibilities held by each person. This frame helps to create the safety to take risks and the support to become empowered to change. As a patient in psychotherapy, you have certain rights that are important for you to know about because this is your therapy, whose goal is your well-being. There are also certain limitations to those rights that you should be aware of. As a therapist, I have corresponding responsibilities to you.

MY RESPONSIBILITIES TO YOU AS YOUR THERAPIST

CONFIDENTIALITY

With the exception of certain specific exceptions described below, you have the absolute right to the confidentiality of your therapy. I cannot and will not tell anyone else what you have told me, or even that you are in therapy with me without your prior written permission. Under the provisions of the Health Care Information Act of 1992, I may legally speak to another health care provider or a member of your family about you without your prior consent, but I will not do so unless the situation is an emergency. I will always act so as to protect your privacy even if you do release me in writing to share information about you. You may direct me to share information with whomever you choose, and you can change your mind and revoke that permission at any time. You may request anyone you wish to attend a therapy session with you.

You are also protected under the provisions of the Federal Health Insurance Portability and Accountability Act (HIPAA). This law ensures the confidentiality of all electronic transmission of information about you. Whenever I transmit information about you electronically (i.e., sending bills or faxing information), it will be done with special safeguards to ensure confidentiality.

If you elect to communicate with me by email at some point in our work together, please be aware that email is not completely confidential. All emails are retained in the logs of your or my internet service provider. While under normal circumstances no one looks at these logs, they are, in theory, available to be read by the system administrator(s) of the internet service provider.

The following are legal exceptions to your right to confidentiality. I would inform you of any time when I think I will have to put these into effect.
The law protects the privacy of all communications between a patient and a clinician. In most situations, I can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. Your signature on this Agreement provides consent for those activities, as follows:

- I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The other professionals are also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together. I will note all consultations in your Clinical Record (which is called "PHI" in my Notice of Clinician's Policies and Practices to Protect the Privacy of Your Health Information).
- You should be aware that I utilize online billing and record services called Theranest. For information on this program, you can visit their website www.theranest.com. The Theranest system is shared by all the clinicians at Baker Street Behavioral Health. If you happen to know one of the therapists and would like to ensure they cannot view your records, please discuss this with your therapist.
- If a patient threatens to harm themself, I may need to break our confidentiality agreement and be obligated to seek hospitalization for them, or to contact family members or others who can help provide protection.

There are some situations where I am permitted or required to disclose information without either your consent or Authorization:

- If you are involved in a court proceeding and a request is made for information concerning the professional services that I provided you, such information is protected by the therapist-patient privilege law. I cannot provide any information without your written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.
- If a government agency is requesting the information for health oversight activities, I may be required to provide it for them.

- If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
- If I am providing treatment for conditions directly related to a worker's compensation claim, I may have to submit such records, upon appropriate request, to Chairman of the Worker's Compensation Board on such forms and at such times as the chairman may require.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm and I may have to reveal some information about a patient's treatment.

- If I receive information in my professional capacity that gives me reasonable cause to suspect that child abuse or neglect has or is occurring and abuse of a dependent or elder adult has or is occurring, the law requires that I report to the appropriate governmental agency, usually the statewide central register of child abuse and maltreatment, or the local child protective services office or adult protective services agency. Once such a report is filed, I may be required to provide additional information.
- If a patient communicates an immediate threat of serious physical harm to an identifiable victim, I may be required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient.

If such a situation arises, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and I am not an attorney. In situations where specific advice is required, formal legal advice may be needed.

The next is not a legal exception to your confidentiality. However, it is a policy you should be aware of if you are in *couples therapy* with me.
If you and your partner decide to have individual sessions as part of the couples therapy, what you say in those individual sessions will be considered to be a part of the couples therapy, and can and probably will be discussed in our joint sessions. *Do not tell me anything you wish kept secret from your partner.* I will remind you of this policy before beginning such individual sessions.

MINORS & **PARENTS**
Patients under 18 years of age who are not emancipated and their parents should be aware that the law may allow parents to examine their child's treatment records. Even where parental consent is given, children over age 12 may have the right to control access to their treatment records. While privacy in psychotherapy is very important, particularly with teenagers, parental involvement is also essential to successful treatment, particularly with younger children. For children age 12 and over, I request an agreement between my patient and their parents allowing me to share general information about the progress of the child's treatment and their attendance at scheduled sessions. I will also provide parents with a summary of their child's treatment when it is complete. Any other communication will require the child's Authorization, unless I feel that the child is in danger or is a danger to someone else, in which case, I will notify the parents of my concern.

For minors, it is my usual practice to share treatment goals and general progress with parents on a regular basis. However, in order for my work with your child to be effective, they need to feel that they have some privacy in their relationship with me. Therefore, I typically do not share the details of each session with parents. If necessary, we (I, the child, and parents) will agree upon specific topics that will be discussed with parents on a regular basis. In the event that I feel the child is in some kind of danger, or if I become aware of a significant issue related to the child's well-being, I will notify the parents of my concern. All parties that have legal custody of the child have the right to information regarding their treatment, and all parties with legal custody must provide consent for the child's treatment in writing. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections they may have.

PROFESSIONAL RECORDS
I keep very brief records, noting only that you have been here, what interventions happened in session, and the topics we discussed. If you prefer that I keep no records, you must give me a written request to this effect for your file and I will only note that you attended therapy in the record. Under the provisions of the Health Care Information Act of 1992, you have the right to a copy of your file at any time. You have the right to request that I correct any errors in your file. You have the right to request that I make a copy of your file available to any other health care provider at your written request. I maintain your records in a secure location that cannot be accessed by anyone else.

DIAGNOSIS
If a third party such as an insurance company is paying for part of your bill, I am normally required to give a diagnosis to that third party in order to be paid. Diagnoses are technical terms that describe the nature of your presenting symptoms. If I do use a diagnosis, I will discuss it with you. All of the diagnoses come from the International Classification of Diseases titled the ***ICD-1OCM.***

OTHER RIGHTS
You have the right to ask questions about anything that happens in therapy. I'm always willing to discuss how and why I've decided to do what I'm doing, and to look at alternatives that might work better. You can feel free to ask me to try something that you think will be helpful. You can ask me about my training for working with your concerns, and can request that I refer you to someone else if you decide I'm not the right therapist for you. You are free to leave therapy at any time.

MANAGED MENTAL HEALTH CARE

If your therapy is being paid for in full or in part by a managed care firm, there are usually further limitations to your rights as a client imposed by the contract of the managed care firm. These may include their decision to limit the number of sessions available to you, to decide the time period within which you must complete your therapy with me, or to require you to use medication if their reviewing professional deems it appropriate. They may also decide that you must see another therapist in their network rather than me. Such firms also usually require some sort of detailed reports of your progress in therapy, and on occasion, copies of your case file, on a regular basis. I do not have control over any aspect of their rules. However, I will do all that I can to maximize the benefits you receive by filing necessary forms, when requested, and assisting you in advocating with the Managed Care company as needed.

BASIC FACTS ABOUT THERAPY

Therapy also has potential emotional risks. Approaching feelings or thoughts that you have tried not to think about for a long time may be painful. Making changes in your beliefs or behaviors can be scary, and sometimes disruptive to the relationships you already have. You may find your relationship with me to be a source of strong feelings, some of them painful at times. It is important that you consider carefully whether these risks are worth the benefits to you of changing. Most people who take these risks find that therapy is helpful.

You normally will be the one who decides therapy will end, with three exceptions. If we have contracted for a specific short-term piece of work, we will finish therapy at the end of that contract. If I am not, in my judgment able to help you, because of the kind of problem you have or because my training and skills are in my judgment not appropriate, I will inform you of this fact and refer you to another therapist who may meet your needs. If you are violent towards, threaten (verbally or physically), or harass myself, the office, or my family, I reserve the right to terminate you unilaterally and immediately from treatment. If I terminate you from therapy, I will offer you referrals to other sources of care, but cannot guarantee that they will accept you for therapy.

I may be away from the office several times in the year for extended periods of time. If I am not taking and responding to phone messages during those times, I will have someone cover my practice. I will tell you well in advance of any anticipated lengthy absences, and give you the name and phone number of the therapist who will be covering my practice during my absence. I am available for brief between session phone calls during normal business hours. If you are experiencing an emergency when I am out of town, or outside of my regular office hours, please call the Crisis Hotline (201) 262-4357. If **you believe that you cannot keep yourself safe, please call 911, or go to the nearest hospital emergency room for assistance.**

YOUR RESPONSIBILITIES AS A THERAPY PATIENT

You are responsible for coming to your session on time and at the time we have scheduled. Sessions last for 45 minutes. If you are late, we will end on time and not run over into the next person's session. If you miss a session without canceling, or cancel with less than twenty-four hours' notice, you must pay for that session at our next regularly scheduled meeting. The answering machine has a time and date stamp which will keep track of the time that you called me to cancel.

You are responsible for paying for your session weekly unless we have made other firm arrangements in advance. Please check with me for rates for families, couples, and group therapy. If we decide to meet for a longer session, I will bill you prorated on the hourly fee. Emergency phone calls of less than ten minutes are normally free. However, if we spend more than 16 minutes in a week on the phone, if you leave more than sixteen minutes' worth of phone messages in a week, or if I spend more than 16 minutes reading and responding to emails from you during a given week, I will bill you for a standard session. Fees are subject to change at our discretion. If a fee change is approaching, I will remind you of this well in advance.

Baker Street Behavioral Health employs out-of-network providers. It is your job to interact with your insurance company and to make sure that you understand how much you will be reimbursed. If a check is mailed to you to cover your balance due, you are responsible for paying me that amount at the time of our next appointment.

I cannot accept barter for therapy. You will be responsible for payment at the end of each session, unless other arrangements have been made. I require all clients to provide current credit card information to the office and it will be billed in the case of nonpayment.

CANCELLATIONS

I require 24-hour notice prior to canceling your session. Sessions cancelled within 24 hours before our meeting time will be charged $75. I require all clients provide current credit card information to the office and it will be billed in the instance of a late cancellation or missed session.

COMPLAINTS

If you're unhappy with what's happening in therapy, I hope you'll talk about it with me so that I can respond to your concerns. I will take such criticism seriously, and with care and respect. If you believe that I've been unwilling to listen and respond, or that I have behaved unethically, you may contact any of the Directors of Baker Street Behavioral Health. Additionally, you may contact the appropriate state licensing board.