ALICIA R. VIDAL-ZAS, PSY.D
CLINICAL PSYCHOLOGIST
14225 SW 42nd Street
Miami, Florida 33175
Office: (305) 221-8200
Fax: (305) 221-9800
www.drvidalzas.com

CONSENT FOR TREATMENT

Date: _____

1) I hereby give informed consent to Dr. Vidal-Zas to evaluate and/or treat myself and/or my family members. **FOR MINORS ONLY**: I, _____, attest that as the parent of this patient I have the right to consent to non-emergency therapy.

2) I authorize the release of medical information to process an insurance claim for services rendered and I authorize payment of health care benefits to Dr. Vidal-Zas.

3) I understand that I am responsible for the full amount of my bill for services provided.

4) It is my responsibility to pay any deductible, co-pay, co-insurance amount or any other balance not aid by your insurance the day and time service provided.

5) It is my responsibility to inform the office of all insurances applicable to the patient and/or any changes made.

This authorization is given voluntarily with knowledge of purpose, free from duress or undue influence and mental capacity.

_____ _____
Guardian's Signature Guardian's Signature

Cancellation of appointments, Termination policy, check policy, and credit card processing fee:
1) There is a 24- hour cancellation policy which requires that you cancel your appointment 24 hours in advance between the hours of 8AM to 4PM, Monday through Friday to avoid being charged **$35.00** penalty fee.
2) Termination of treatment due to non-compliance entails (3) No-shows to visits or (5) cumulative cancellations during treatment.
3) There will be a **$25.00** service charge on all returned checks.
4) There will be a **$1.00** convenience fee for all routine outpatient co-pays made via credit card.

_____ _____
Guardian's Signature Guardian's Signature

Authorization of Communication with PCP

_____ □ I give consent for Dr. Vidal-Zas to report back, to my primary care physician, if necessary or to coordinate treatment, as required by insurance company policies. This report is for the purpose of informing them a) that I have begun psychotherapy, b) of my initial diagnosis, and c) to occasionally let them know if I continue treatment. This consent does not cover the release of information that I may disclose during my treatment sessions.

Physician's Name: _____ Phone# (____) _____

_____ □ I refuse to provide consent of communication with the primary care physician.
Reason for refusal: _____

_____ _____
Guardian's Signature Guardian's Signature

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

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

- Provide, coordinate, or manage your health care and any related services.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations.

I have received, read, and understand the Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. 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 any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Guardian's Signature / Relation _____ Date _____
Guardian's Signature / Relation _____ Date _____
Responsible Party/Relation _____

MEMBERS RIGHTS AND RESPONSIBILITIES

My signature below shows that I have been informed of my rights and responsibilities, and that I understand this information.
Guardian's Signature _____ Date _____
Guardian's Signature _____ Date _____

The signature below shows that I have explained this statement copy of this form to the patient. I have offered the member a copy if requested.

Provider Signature _____ Date _____

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PSYCHOTHERAPIST-PATIENT SERVICES AGREEMENT
OUTPATIENT SERVICES CONTRACT

Welcome to my practice. This document (the Agreement) contains important information about my professional services and business policies. Please read it carefully and jot down any questions that you might have so that we can discuss them at next meeting. Once you sign this, it will constitute a binding agreement between us.

PSYCHOLOGICAL SERVICES
Psychological assessment and psychotherapy are not easily described in general statements. They vary depending on the personalities of the psychologist and patient, and the particular problems the patient is experiencing. There are many different methods I may use to deal with the problems that you hope to address. Neither psychological assessment nor psychotherapy is like a medical doctor visit. Instead, it calls for a very active effort on the patient part. In order for the assessment to be successful, the patient will have to participate in the testing. In order for the therapy to be most successful, the patient and the patient's family will have to work on things discussed both during treatment sessions and at home.

Psychological assessment and psychotherapy can have benefits and risks. Psychological assessment involves determining whether the patient exhibits delays or deficits. Therapy often involves discussing unpleasant aspects of the patient's life. Consequently, the patient and/or the patient's family may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychological assessment and psychotherapy have also been shown to have many benefits. They often lead to the amelioration of delays/deficits, to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what the patient or the patient's family will experience.

MEETINGS:
The first sessions will involve an evaluation of the patient's functioning/needs. By the end of this period, I will be able to offer recommendations. In the case of psychotherapy, I will offer some first impressions of what treatment will include and a treatment plan to follow. If you decide to continue with therapy, you should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, I should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

Psychological evaluations are conducted over 2 to 4 sessions. Instruments chosen for testing are based on the age or mental functioning of the patient and the presenting problem. Assessment results are discussed at the end of the evaluation. Recommendations are also made at that time. If psychotherapy is to begin, the therapist will usually schedule one 35 to 50-minute session (one appointment hour of 30 or 50 minutes duration) at an agreed upon time, although some sessions may be longer or more frequent. Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation or unless we both agree that you were unable to attend due to circumstances beyond your control. It is important to note that insurance companies do not provide reimbursement for cancelled sessions.

PROFESSIONAL FEES
My fee for the initial visit is $220.00 and $185.00 for follow up sessions. In addition to weekly appointments, I charge this amount for other professional services the patient may need, though I will break down the hourly cost if I work for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than 10 minutes, consulting with other professionals with appropriate permission, preparation of records or treatment summaries, and the time spent performing any other service requested of us. If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge $450.00 per hour for preparation and attendance at any legal proceeding. Calls lasting longer than 10 minutes will be considered telehealth sessions (phone calls / no video calls). These need to be pre-scheduled and paid prior to appointment time. 45-minute telehealth sessions will incur a $125 fee and the lowest session rate is $85 for 30 minutes.

COPIES: In most circumstances, I will charge a customary copying fee of $1.50 per page (and for certain other expenses). I may withhold copies of the records until payment of the copying fees has been made. If I refuse your request for access to the records, you have a right of review, which I will discuss with you upon request.

CONTACTING MY OFFICE
Due to my work schedule, I am often not immediately available by telephone. While I am usually in my office between 8am and 8pm, I probably will not answer the phone when I am with a patient. When I am unavailable, my phone extension is answered by a personal and secured voice mail,

Initials _____ _____

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which I monitor frequently. Text messages confirmations for appointments are facilitated; however, the text service is not intended to transmit personal information to your clinician. I make every effort to return patient's calls on the same day, with the exception of weekends and holidays. If you are unable to reach me, contact your family physician or the nearest emergency room and ask for the psychologist/psychiatrist on call. When I am unavailable for an extended time, I provide you with emergency contact numbers, if necessary.

BILLING AND PAYMENTS:
Payment is expected for each session at the time it is held, unless I agree otherwise or unless insurance coverage requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested. In circumstances of unusual financial hardship, I may be willing to negotiate a fee adjustment or payment installment plan.
If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require us to disclose otherwise confidential information. In most collection situations, the only information I release regarding a patient's assessment/treatment is his/her name, the nature of services provided, and the amount due. If such legal action is necessary, its costs will be included in the claim.

INSURANCE REIMBURSEMENT:
In order for me to set realistic assessment/treatment goals and priorities, it is important to evaluate what resources the patient (or the patient's legal representative) has available to pay for the assessment/treatment. Health insurance policies usually provide some coverage for psychological assessment/mental health treatment. I will fill out forms and provide whatever assistance I can to accelerate the processing of insurance claims; however, the patient (or the patient's legal representative, not the insurance company) is responsible for full payment of my fees. It is very important that you find out exactly what mental health services your insurance policy covers.

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Of course, I will provide you with whatever information I can based on my experience and will be happy to help you in understanding the information you receive from your insurance company. If it is necessary to clear confusion, I will be willing to call the company on your behalf.
Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. "Managed Health Care" plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. These plans are often limited to certain types of assessment or to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. In the case of psychotherapy, it may be necessary to seek approval for more therapy after a certain number of sessions. While much can be accomplished in short-term therapy, some patients may need more services after insurance benefits end. Some managed-care plans will not allow us to provide services to patients once benefits end. If this is the case, I will do my best to find another provider who will help with the continuation of psychotherapy.

You should also be aware that your contract with your health insurance company requires that I provide it with information relevant to the services that I provide the patient. I am required to provide a clinical diagnosis. Sometimes I am required to provide assessment results or additional clinical information such as treatment plans or summaries, or copies of the patient's entire Clinical Record. In such situations, I will make every effort to release only the minimum information necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit, if you request it. By signing this Agreement, you agree that I can provide requested information to your carrier.

Once I have all of the information about your insurance coverage, I will discuss what I can expect to accomplish with the benefits that are available and what I can do to complete that part of an assessment that is not covered by insurance. Also discussed will be what will happen if benefits run out before the patient is ready to end treatment. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above.
Your signature below indicates that you have read the information in this document and agree to abide by its terms during my professional relationship.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ABIDE BY ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

Guardian's Name _____ Signature _____ Date _____
Guardian's Name _____ Signature _____ Date _____