FILASKI PSYCHOLOGICAL CARE, P.C.

DR. KRISTEN FILASKI, PSY. D.
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(631) 403-0064

PATIENT INFORMATION

Name:______________________________ DOB:______________

Street Address:____

Town:______________________________ Zip Code:______________

Home Phone: __________________ Cell Phone: ____________________

Work Phone: __________________ Cell Phone: ____________________

Email:____

Referral Source:____

EMERGENCY CONTACT INFORMATION

Name:______________________________ Relation:______________

Home Phone:_________________ Cell Phone: ______________________

INSURANCE INFORMATION

Insurance Company Name: ______________________________________

Identification Number:____

Insurance Company Phone Number:_______________________________

Policy Holder's Name:______________________ DOB:______________

Social Security Number: ____________________ Sex:______________

AGREEMENT TO PAY FOR PROFESSIONAL SERVICES

*Please Read and Initial below:

______ I request that my therapist provide professional services to me and/or my child.

______ I agree to pay a fee of:

- **$160.00** for the initial intake/consultation
- **$140.00** per session for ongoing therapy services
- **Unless using health insurance that the provider is enrolled with OR otherwise agreed upon in writing.**

______ I agree that I am responsible for the charges for services provided by this therapist to me.

______ I understand that **NO SHOW** or **Appointments Canceled Without 24 Hour Written Notice** via text or email will be charged directly to the client's credit card on file at a rate of **$50.00**

______ I understand that Copays and Deductibles must be paid at the time of service or they will be charged directly to the client's credit card on file.

CREDIT CARD INFORMATION

______ I understand that a credit card must be kept on file in the event that a late cancellation or no show fee is incurred. Cards are not stored electronically unless using STRIPE, they are kept in a secure locked location. If you are not willing to leave a card on file, future appointments will not be scheduled. Return checks are subject to a $40.00 return fee.

Cardholder's Name:____

Credit Card Number: __________ - __________ - __________ - __________

Expiration Date: ______ / ______ CVV__________ ZIP Code:________

METHODS OF PAYMENT

You may pay by:

- Cash
- Credit Card (Mastercard, Visa, AMEX, Discover, HSA cards accepted)
- Check (Make checks payable to: **Filaski Psychological Care, P.C.**)

ASSIGNMENT OF BENEFITS & PAYMENT DETAILS

Please note that if your account is unpaid and we have not arranged a payment plan, legal means to obtain payment will be used. The only information that will be given to the court or collection agency will be your name, address, dates of services, and the amount due to the the therapist. You will be charged an additional 50% of your unpaid balance if sent to collections. All account balances that are unpaid will be assessed a $25.00 late charge every 30 days. All accounts will be sent to collections after 90 days past due.

I am aware that I am responsible for any amount not covered by my insurance company carrier including the deductible, and that my copayment is due at the time of services rendered. I agree to assign all medical benefits to include major medical benefits to which I am entitled, including Medicare, other government sponsored programs, private insurance, and any other health plans to: Filaski Psychological Care, P.C.

I understand that I am financially responsible for any charges whether or not they are paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment of said benefits. My signature below means that I understand and agree with all of the points above.

____ ____________________

Signature of Client (or person acting for client) Date

CONSENT TO TREATMENT

I acknowledge that I have received, have read (or have had read to me), and understand the process and information about the therapy I am considering. I have had all my questions answered fully. I do hereby seek and consent to take part in the treatment by the therapist named below. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist. I am aware that I may stop my treatment with this therapist at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may have to deal with other problems if I stop treatment. (For example, if my treatment is court-ordered, I will have to deal with the court.)

I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive. I understand that if payment for the services I receive here is not made, the therapist may stop my treatment. My signature below shows that I understand and agree with all of these statements.

____ ____________________

Signature of Client (or person acting for client) Date

OUR AGREEMENT FOR THERAPY

I agree to meet with the therapist named below at the appointment times and places we agreed upon. I have read all the materials on therapy, which have been provided to me by the therapist on their website. I believe I understand the basic ideas, goals, and methods or this therapy. I have no important questions or concerns that therapist has not discussed.

With enough knowledge, and without being forced, I enter into treatment with this therapist. I will keep my therapist fully up to date about any changes in my feelings, thought, and behaviors. I expect us to work together on any difficulties that occur, and to work them out in my long-term interest. During this process we will evaluate progress and may change parts of this agreement as needed. Our goals may have changed in nature, order of importance, or definition. If I am not satisfied by our progress toward goals, I will attempt to make change in this agreement. I may also stop treatment after giving this therapist appropriate (i.e., generally one week) notice of my intentions. I also understand that any information in this recording that could identify me in any way will not be published or given without my written consent.

My signature below means that I understand and agree with all of the points above.

____ ________________

Signature of Client (or person acting for client) Date

I, the therapist, have discussed the issues above with the client. My observations of this client's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

____ ________________

Signature of Client (or person acting for client) Date

***This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law*

<u>INFORMED CONSENT TO TELETHERAPY</u>

Teletherapy includes consultation, treatment, transfer of medical data, emails, telephone conversations, text messaging and education using interactive audio, video, or data communications. I hereby consent to participate in psychotherapy via telephone or the internet (hereinafter referred to as Teletherapy) with the clinician below:

Client Name:______________________________ Clinician:_________________________________

<u>I understand I have the following rights under this agreement:</u>
I have a right to confidentiality with Teletherapy under the same laws that protect the confidentiality of my medical information for in-person psychotherapy. Any information disclosed by me during the course of my therapy is generally confidential. There are, by law, exceptions to confidentiality, including mandatory reporting of child, elder, and dependent adult abuse and any threats of violence I may make towards a reasonably identifiable person. I understand that if I am in such a mental or emotional condition to be a danger to myself or others my therapist has the right to break confidentiality to prevent the threatened danger. Further, I understand that the dissemination of any personally identifiable images or information from the Teletherapy interaction to any other entities shall not occur without my written consent.

I understand the benefits of Teletherapy to be convenience, increased access to therapist, easy of scheduling and continuation of care. While psychotherapeutic treatment of all kinds has been found to be effective in treating a wide range of mental disorders, personal and relational issues, there is no guarantee that all treatment of all clients will be effective. Thus, I understand that while I may benefit from Teletherapy, results cannot be guaranteed or assured.

I further understand that there are specific risks to Teletherapy, including but not limited to, the possibility that our therapy sessions or other communication regarding my treatment could be disrupted or distorted by technical failures; could be interrupted; or could be accessed by unauthorized persons. In addition, I understand that Teletherapy treatment is different from in-person therapy and that if my therapist believes I would be better served by another form of psychotherapeutic services, such as in-person treatment, I will be referred to a therapist in my area.

I understand that I must adhere to the Teletherapy Policies of Filaski Psychological Care, P.C. (attached).

I have read and understand the information provided above. I have the right to discuss any of this information with my therapist and understand that I can withdraw my consent to Teletherapy via written means. My signature indicates I have read this agreement and agree to its terms.

Client Signature: ____ Date:____________________

TELETHERAPY POLICY & SOCIAL MEDIA POLICY

VIDEO SESSIONS

1. Facetime will be used for all Video Sessions as it is considered a HIPAA compliant video call service.

2. I, the therapist will Facetime you the client at the appointed time. In the event of a technological failure, I will make two attempts to Facetime you back. If they do not go through, you will receive a text message from me indicating how to proceed.

3. If the connection cannot be made via FaceTime due to technical difficulties, I will suggest we switch to an audio session (either FaceTime Audio only or a general phone call at an agreed upon number).

4. You the client are responsible for arranging a location with sufficient lighting, internet connectivity, and privacy that is free from distractions or intrusions for your sessions.

PHONE COMMUNICATION

1. Phone calls are scheduled via email with the therapist on an as needed basis.

2. I, the therapist will call you the client at the scheduled time. In the event of a call failure, I will make two attempts to call you back. If they do not go through, you will receive a text message or email from me indicating how to proceed.

3. Phone messages are returned only on Mondays and Wednesdays. If you need to request/schedule a call, email your therapist as emails are reviewed daily and a more immediate response is given.

EMAIL AND TEXT COMMUNICATION

1. Emails and Texts are reviewed daily but may not be returned until the end of the day.

2. Texting should ONLY be used for: schedule changes; requests for appointments from existing clients; therapist-sent therapeutic worksheets/tools. Any case-related information should be sent via email.

SOCIAL MEDIA POLICY

I do not accept friend requests from current or former clients on any social networking sites EXCEPT for my Instagram business account: Filaskipc. On Instagram I do not respond to direct messaging, all are redirected to my website. This is to protect your confidentiality and our respective privacy as well as for the maintenance of boundaries to our therapeutic relationship.

****Teletherapy DOES NOT provide emergency services.** If you are experiencing an emergency situation, you can call 911 or proceed to the nearest hospital emergency room for help. If you are having suicidal thoughts or making plans to harm yourself, you can call the National Suicide Prevention Lifeline at 1-800-273-TALK for free 24 hour hotline support.

Client Signature:____ Date:____________________