

# Dynamic Behavioral Consulting

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## PSYCHOLOGICAL SERVICES AGREEMENT & POLICIES: PAGE 1 OF 2

This form provides you with information that is in addition to that detailed in the *Florida Notice Form: Notice of Mental Health Practitioner's Policies & Privacy Practices (HIPAA Leaflet)*.

### CONSENT FOR PRACTITIONER

I am choosing to enter into psychological services with \_\_\_\_\_ at Dynamic Behavioral Consulting. I am, therefore, consenting to the treatment with the above practitioner. I understand that at any time, I have the authority to exercise my right and terminate behavioral health services with this practitioner. I also, understand that the office is comprised of independent practitioners who are each solely responsible for their own practice and that the practitioners should not be considered liable for the practice of the others at the office.

Patient's Signature:

Date:

\_\_\_\_\_

\_\_\_\_\_

Parent / Guardian's Signature:

Date:

\_\_\_\_\_

\_\_\_\_\_

### PAYMENTS

It is usual and customary for the provider and the client to agree upon Fees by the first session. Clients are expected to pay at the beginning of each session unless agreed otherwise. Initial consultations are 50-60 minutes long, subsequent Individual sessions are 45-50 minutes long; double-sessions are 1-½ hours in length. Telephone conversations, report writing, consultation with other professionals, releases, longer sessions, travel time, etc. will be charged at the same rate, unless other arrangements are made. Please notify your practitioner if any problem arises regarding your ability to make timely payments.

Payments From Clients Using Insurance: Not all issues that are the focus of psychotherapy are reimbursed by insurance companies. It is your responsibility to verify the specifics of your coverage. As indicated above in Health Insurance & Confidentiality of Records, you must be aware that submitting a mental health invoice for reimbursement carries some risk.

Clients utilizing insurance (in-network): Co-payments and deductible amounts are due at the time of service unless special arrangements have been made. The billing department of Dynamic Behavioral Consulting will gladly file insurance claims on your behalf; however, payments cannot be guaranteed. You will need to understand that the billing department will make every effort and several attempts to obtain payments and/or clarify your insurance carrier's decision regarding your outstanding balance. In the event that the insurance company misquoted your benefits, changed your benefits, or any other reason that the insurance company denies your claim, you will be responsible for any unpaid balances not covered by your insurance company.

Clients utilizing Insurance (out-of-network): If I am an in-network provider for your insurance carrier, then you are responsible for making payment of the agreed upon fee for services at the beginning of each session. Unless agreed upon differently, I will provide you with a receipt on a monthly basis, which you can then submit to your insurance company for reimbursement.

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## PSYCHOLOGICAL SERVICES AGREEMENT & POLICIES: PAGE 2 OF 2

### RESPONSIBILITY FOR UNPAID BALANCES

Payments, co-payments, and deductible amounts are due at the time of service unless special arrangements have been made. I understand that the billing department of Dynamic Behavioral Consulting will gladly file insurance claims on my behalf; however, payment cannot be guaranteed. I understand that the billing department will make every effort and several attempts to obtain payments and/or clarify my insurance carrier's decisions regarding my outstanding balance. In the event that the insurance company misquoted my benefits, my benefits changed, or any other reason that the insurance company denies my claim, I will be responsible for any unpaid balances not covered by my insurance company.

Client's Signature:

Date:

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Parent / Guardian's Signature:

Date:

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### CANCELLATION POLICY

I am also acknowledging my understanding that since my appointment time has been set aside exclusively for me, that I am responsible for notifying my practitioner 24 hours in advance to avoid a \$55 cancellation fee. I am aware that my insurance company will not pay for missed appointments.

Client's Signature:

Date:

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Parent / Guardian's Signature:

Date:

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