COGNITIVE THERAPY ORANGE COUNTY

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Psychological Services Information and Informed Consent
Addendum for Responsible Financial Party

This addendum is for patients who designate another individual as financially responsible for their treatment fees. Such persons are referred to in this document as "**Responsible Financial Party (RFP)".** The terms "clinician" and "provider" are interchangeable and refer to licensed psychologists or licensed clinical social workers providing service. The term "patient" refers to the individual receiving treatment.

Professional Fees and Insurance. The **RFP** is expected to pay for each appointment at the time service is rendered, as described below on this form, in **Fee Payment Schedule** section. Fee for initial consultation is $250.00. Fee per session is $ 200.00. Telephone conversations with patients in excess of 5 minutes will be billed at the regular appointment fee, in quarter hour increments. Report writing will be billed at the regular appointment fee, in quarter hour increments. Consultation with other professionals will be billed at the regular appointment fee, in quarter hour increments.

Billing Statements: A Billing Statement will be mailed to the **patient** indicating a zero balance due to Cognitive Therapy Orange County (CTOC) when full payment is received. This statement can be used for insurance billing purposes.

CTOC **does not provide any services** under "managed care" plans such as HMO's, PPO's, MEDICARE, etc. The clinician can discuss this in detail if there are specific questions. CTOC providers are "out-of-network providers".

Mental health coverage varies between health insurance companies. If there are questions about insurance coverage, the patient should contact their insurance company. The phone number can usually be found on the back of the patient's insurance card. Reimbursement for services is at the direction of the patient's insurance company as indicated by the specific health care plan, and **this contract is between the patient and their insurance company.**

Patient Confidentiality. Patient confidentiality requires that all communication between the patient and clinician is private as indicated by California law and not subject to disclosure unless written authorization is provided by the patient. The RFP has no right to information about attendance, treatment plan, treatment status, or treatment outcome, despite agreeing to pay for services provided to the patient, unless patient provides written authorization for the clinician to disclose such information to the RFP, or RFP is the parent or legal guardian of patient and patient is under 18 years old.

Cancellations. Because an hour is reserved for the patient's appointment time, it is requested that the patient give CTOC 24 hour notice of cancellation. If cancellation is not given, the patient will be charged the full regular fee. **The RFP is responsible for these charges.** If the patient believes circumstances surrounding a particular cancellation deserve an exception to this policy, the patient can discuss this with the clinician.

Fee Payment Schedule: At the time of service. Balance due not to exceed $ 250.00

- If there are questions or concerns regarding the above information, please discuss them with the clinician.
- I understand and agree with the statements written on this document and, if requested, have received copy of the same.
- I _____ agree to pay CTOC for all services rendered to _____,
  Responsible Financial Party (RFP) Printed Name — Patient Printed Name

  in accordance with the above described Fee Payment Schedule.

RFP Signature _____ Date ___/___/___.

Provider Signature _____ License Number _____ Date ___/___/___.