**A. Keith Barton, Ph.D., P.C.**
**146 Danbury Rd., Ste. D • New Milford, CT 06776**
**(281) 773-8837 office • (860) 799-5902 fax**

## PATIENT INFORMATION

Name: _____ Date of Birth: _____

Gender: Male Female Marital Status: S M D W Are we filing on your insurance? Yes No

Home Address: _____ City: _____ State: _____ Zip: _____

Home #: _____ Cell #: _____ Work #: _____

Employer/School: _____ Occupation: _____

Primary Care Physician: _____ Psychiatrist: _____

In case of emergency: _____ Relationship: _____

How did you hear about us? _____ Email address: _____

## IF PATIENT IS UNDER 18 YEARS OF AGE

Mother's Name: _____ Father's Name: _____

Home #: _____ Cell # _____ Home #: _____ Cell # _____

Work #: _____ Work #: _____

## BILLING PARTY INFORMATION (IF DIFFERENT THAN PATIENT)

Relationship to Patient: Spouse Parent Other _____

Billing Name: _____ Date of Birth: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Home #: _____ Cell #: _____ Work #: _____

Employer/School: _____ Occupation: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

## Overview of Therapy

As a Licensed Psychologist, I do not prescribe medication, but I am trained in a broad range of therapeutic techniques. The goal of therapy is to help you resolve the problems for which you are seeking treatment. Although it is impossible to guarantee any specific results regarding your therapeutic goals, I will work with you as conscientiously and diligently as I can to achieve the best possible results. If you ever have questions about my services or are dissatisfied with them, please let me know. I will provide other treatment options and/or referrals as necessary.

While our sessions might be psychologically intimate, it is important for you to realize that our relationship is professional rather than social. Other than chance meetings, our contact will be limited to the appointments you arrange with me. I cannot and will not attend social gatherings, accept gifts, or relate to you in any way other than in the professional context of our therapy sessions. As a patient, you will be best served if our relationship remains strictly professional. Unlike a friendship, our therapeutic relationship will concentrate exclusively upon your goals and concerns. While you might learn about me as we work together, it is important for you to remember that you are experiencing me solely in my professional role.

## Confidentiality

The information that you provide in therapy is confidential and will not be shared with anyone without your written consent as prescribed under Federal Law 42 CFR Part 2, and the Health Insurance Portability and Accountability Act (HIPAA). However, there are a few circumstances when confidentiality, by law, will not be maintained, including the following:

- Concern of imminent harm to yourself (suicide) or others (homicide);
- Crucial information regarding your physical or emotional well-being;
- Litigation brought against Dr. Barton by the patient;
- Suspicion of child abuse or elder abuse;
- Order for release of records by a Judge or District Attorney;
- Requirement for mental health services from your insurance, disability, etc.
- Necessity for collection of any outstanding balance; or
- Any other situation required by law – e.g. copy of divorce decree and/or legal guardianship

## Sessions/Fees

- Therapy sessions are typically 45-50 minutes in length. The remainder of the hour is used to chart notes, file insurance claims, and return client phone calls.

- The cash price of the initial office visit fee is $150.00, and the cash fee for subsequent visits is $125.00. Any fees incurred are due at the time services are rendered. Acceptable forms of payment include cash, money order, MasterCard, or Visa. Unfortunately, I am no longer able to accept checks.

- Should six or more consecutive months lapse in your treatment, you will be considered a new patient upon your return, and new patient fees and procedures will apply.

- There is a minimum $25.00 fee for each request for medical records or letter written on the patient's behalf.

## Insurance

Please remember that as a mental health provider, my relationship is with you, not your insurance company. Your mental health coverage is a contractual agreement between you, your employer, and the insurance company. I am not a party to that contract. Not all services qualify as covered benefits under all contracts. My Staff will assist you in verifying your eligibility and benefits; however, it is ultimately your responsibility to know what services are covered by your carrier.

My Staff will file your insurance claim only if I am an in-network provider with your mental health carrier. My Staff will not file insurance claims for any out-of-network benefits, but we will provide you with the receipt necessary for you to file for reimbursement from your carrier. If your mental health coverage changes, my Staff will need at least 48 hours notice prior to your next scheduled appointment to verify eligibility and benefits. Failure to notify us of such changes will result in your having to pay the full fee ($125.00). My Staff will not be responsible for filing past claims to new insurance companies.

My fees are generally considered to fall within the acceptable range of mental health care services, and are therefore covered up to the maximum allowance as determined by each carrier. *While the filing of insurance claims is a courtesy extended to patients, all charges are ultimately your responsibility from the date services are rendered.*

## Appointments and Cancellations

Your appointment time has been reserved specifically for you, and being on time will ensure that you receive the full time scheduled. If you cannot keep a scheduled appointment, kindly call to cancel **at least 24 hours in advance** so that someone else can be seen for treatment during that time.

Regarding your appointment, the following will apply:

• A responsible parent or adult must be present for the entire session for children under age 16. My staff is not responsible for supervising children. If you cannot make appropriate arrangements for your small children, you will need to reschedule your appointment.

• In the interest of public health, if you have a contagious illness, please reschedule your appointment.

• There is no charge for cancellations made at least 24 hours prior to appointment time.

• There is a $45.00 charge for scheduled appointments cancelled less than 24 hours prior to appointment time. This fee cannot be charged to the patient's insurance company, and must be paid by the patient on or before the patient's next scheduled appointment.

• There is a $125.00 charge for scheduled appointments to which you do not show up. This fee cannot be charged to the patient's insurance company, and must be paid by the patient on or before the patient's next scheduled appointment.

• If you are less than 15 minutes late for an appointment, you will be seen only for the remainder of your scheduled appointment.

• If you are more than 15 minutes late for an appointment, the appointment will automatically be cancelled and you will be charged $45.00. This fee cannot be charged to the patient's insurance company, and must be paid on or before the patient's next scheduled appointment. Seeing you for less time and filing the charges with your insurance company is fraudulent and illegal.

• If you miss or cancel 3 scheduled appointments, I will no longer be able to work with you. However, I will provide referral sources to you so that you can continue your treatment.

• Unfortunately, there are occasions when I am behind schedule. In this case, you will receive the full 45-50 minutes of your scheduled appointment.

## Coverage/Emergencies

I am on call for emergency situations 24 hours a day except for a few selected weekends, holidays, vacations, etc. *If you are experiencing imminent danger ora life-threatening emergency, call 911 or go to the nearest emergency room immediately.* If you require emergency assistance during regular business hours, please call my office at (281) 773-8837 and ask to speak with me. If you require emergency assistance after regular business hours or on a weekend or holiday, the office voicemail will direct you to call my pager at (281) 551-0069. Please feel free to call me in a true emergency situation, but be considerate with after-hours calls and use this privilege only in case of an emergency.
Non-emergency calls will usually be answered within the same business day, typically in the evening.
If you call after 5:00 p.m., your call may be answered the next business day.

## Client Rights and Consent Agreement

I understand that I have chosen to undergo therapy, that this choice is voluntary, and that I may terminate treatment at any time. I understand that there is no assurance that I will feel better. Because therapy is a cooperative effort between Dr. Barton and me, I will work in a cooperative manner to resolve my difficulties. I understand that during the course of my treatment, material may be discussed that are of a sensitive nature, and that this may be necessary for me to resolve my problems.

I understand that Dr. Barton, an insurance representative, and/or my physician may exchange any and all information pertaining to my therapy to the extent that such disclosure is necessary for the processing of claims, case management, coordination and/or continuity of treatment, quality assurance, outcome assessment, or utilization review purposes. I understand that I can revoke my consent in writing at any time, except to the extent that treatment has already been rendered or action has been taken in reliance upon this consent. If I do not revoke this consent, it will expire automatically one year after all claims for treatment have been paid as provided in my benefit plan.

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I have provided the above information and certify that this information is true and correct to the best of my knowledge. I will notify Dr. Barton & his Staff if any of this information changes. I also agree that Dr. Barton (or his representative) has my permission to communicate with the Billing Party listed above for the purpose of billing and/or collection.

Confidentiality also should be taken into consideration should Dr. Barton become incapacitated, retire or die. I acknowledge that, in the event Dr. Barton becomes incapacitated, retires or dies, it will become necessary for another licensed mental health professional to take possession of my file and records. By reading this information and signing this consent form, I give my consent to allow another licensed mental health professional selected by Dr. Barton or his office to take possession of my file and provide me with copies, upon request, or to deliver the file to a licensed mental health professional of my choice.

A. Keith Barton, Ph.D.
Licensed Psychologist

**I have read, understand and agree to these policies**

_____ _____

Patient Signature
(Parent/Guardian Signature for Minor Patient)

Date

_____ _____

Patient Name (Printed)

Patient's Date of Birth