Jonathan Dean, LMFT
PO Box 352
Niantic, CT 06357
860-539-0629 fax 860-812-4315
jondean13@yahoo.com

Notice of Privacy Practices

A copy of Notice of Privacy Practices can be found in the waiting room. Please ask for a copy if you have not received or need a copy for your records.

My signature below indicates that I acknowledge that my information can and will be used to

- Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.

- Obtain payment from third party payers.

- Conduct normal health care operations such as quality assessments and certifications.

Client name: _____

Signature: _____ Date:_____

Signature: _____ Date:_____

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Insurance Reimbursement

The signature below indicates that I have been informed of the fact that my insurance company may reimburse me for services received by Jonathan Dean, LMFT. If this should happen I will sign the check and forward' my payments to Jonathan Dean, LMFT for services rendered to me by my provider. I understand that if I do not forward payments to Jonathan Dean. LMFT that I will be billed the full amount that is owed by the insurance company.

I also understand that if the balance is not paid within (30) thirty days from receiving the explanation of insurance benefits from the insurance company and the bill from the office, that a $5.00 billing fee will be added for each day that the balance is unpaid. If the unpaid balance, including billing fees, is not paid within (120) one hundred and twenty days of the original bill date, the balance will be sent into collections.

Client name: _____

Client/Guardian Signature:_____ Date: _____

Witness: Jonathan Dean, LMFT:_____ Date: _____

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No Show/Late Cancellation Policy

In order to provide quality service to you the client is your responsibility to make your appointment times. Jonathan Dean, LMFT requires 24 hour notification if you cannot make your scheduled appointment. Certain exceptions will be forgiven (i.e. weather conditions, illness). Should you cancel more than 3 appointments within a two month period, you-will be notified of your absences and possibly be terminated from care. An appropriate referral will be made in this event

You will be charged a $90.00 no show/late cancellation fee should you fail to notify Jonathan Dean, LMFT of your absence. Please note that you will be responsible to pay this fee at the time of your next appointment.

I understand and agree to-the terms of the No snow and late cancellation policy:

Client/Guardian Signature:_____ Date: _____

Witness: Jonathan Dean, LMFT:_____ Date: _____

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Consent to Treatment

I,_____ ,voluntarily consent to be treated by Jonathan Dean, LMFT. I understand that I have been given no guarantee as to the outcome or results of my treatment. I also understand that when my treatment is complete, or when I discharge myself, this consent will immediately expire.

Client/Guardian Signature:_____ Date: _____

Jonathan Dean, LMFT:_____ Date: _____

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Financial Policy

Please Read Carefully

1. Your payment or co-payment is due at the time of service. If a payment or co- payment is not made at the time of the visit there will be an additional. $5.00: billing. fee due at your next visit.

2. Jonathan Dean, LMFT will submit your insurance claims and assist in working with your insurance company. Ultimately, it is your responsibility to understand your insurance contract between you, your employer, and your insurance company. There may be restrictions and exclusions that may effect payment for this service as well as changes to contracts that you must keep account of. Please let Jonathan Dean, LMFT know if there are changes to your coverage or contract.

3. All outstanding balances that are not covered by your insurance company must be paid in full within 30 days of receiving of service date. Any remaining balance over 120 days from the original date of service will be turned over to collections.

4. If you are a divorced parent bringing your child-in for treatment, you-are the responsible party to this office. You may have legal arrangements that someone other than yourself is ultimately responsible for medical cost. If that is SO then you are responsible to collect the fee from the party you consider responsible for payment before the scheduled appointment so that you can pay at the time of service.

5. Telephone consultation sessions are $-100.00 per hour and $25.00 per 15 minutes and are NOT payable by insurance. This fee will be due at the next scheduled appointment. .

6. If you request attendance by Jonathan Dean. LMFT at a meeting (PPT,trial, etc.) such attendance will be based on the fee schedule posted in the office and provided on this form.

At any time if you are having difficulties paying you bill please call the office so that a payment plan can be arranged. The payment plan will only remain in effect as long as you are paying according to your payment arrangement.

I agree to the terms listed above:

Client/Guardian Signature:_____ Date: _____

Jonathan Dean, LMFT:_____ Date: _____

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Confidentiality

Confidentiality and privileged communication are the rights of all clients working with professionals in the mental health field, according to the law and professional ethics. No information about you or the services provided to you will be released without your permission to do so. Here are some exceptional circumstances in which your mental health provider may be required by law to take immediate action and breach confidentiality.

1. If a court of law issues a legitimate subpoena, your mental health provider is then required to provide any information specifically described in the subpoena.

2. If you indicate that you intend to hurt or kill yourself or another individual, your mental health provider is then obligated to notify potential treatment personnel or victims .if it is believed that there is a real or immediate danger.

3. If you report, or your mental health provider suspects, that you are an active perpetrator or victim of child abuse or molestation, your mental health provider IS then obligated to immediately report this to the authorities.

4. If you are currently in psychotherapy or are being evaluated by order of court of law, the results of the evaluation and/or treatment status may be revealed to your probation officer or the court.

5. If you are a minor, your parents or guardians have the right to be informed of your progress if they request so. This only includes the general status of your progress, not any specific information regarding the conversations that took place within your sessions.

Every effort will be made to discuss with you any breach of confidentiality that is being considered by your mental health provider. If you have any questions, feel free to ask
your provider.

I have read the above document and understand my mental health provider's ethical and legal responsibilities as a professional. I also understand that Jonathan Dean, LMFT is not available 24 hours a day. I therefore, agree to notify my primary doctor or Jonathan Dean, LMFT in advanced so that appropriate arrangements can be made in a timely manner. I also agree to make contact with my doctor or Jonathan Dean, LMFT to any imminent act of dancer to myself or others.

Client Signature:_____ Date: _____

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Primary Insurance Information

Insured Name:_____

Date of birth:_____ Social Security Number:_____

Relationship to client (circle): Self Spouse Parent Other

Insured's Employer:_____

Insurance Company:_____

Insurance Company Phone Number:_____

ID Number:_____ Group Number:_____

By signing below, I authorize the release of any information that is needed to process insurance claim.

Signature:_____ Date:_____

Secondary Insurance Information

Insured Name:_____

Date of birth:_____ Social Security Number:_____

Relationship to client (circle): Self Spouse Parent Other

Insured's Employer:_____

Insurance Company:_____

Insurance Company Phone Number:_____

ID Number:_____ Group Number:_____

By signing below, I authorize the release of any information that is needed to process insurance claim.

Signature:_____ Date:_____

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Patient Information

Date:_____

Name:_____ Date of Birth:_____

Age:_____ Sex: _____ Social Security Number: _____

Home Address:_____

City:_____ State: _____ Zip Code:_____

Home Phone:_____ Cell Phone: _____ Work: _____

Emergency Contact:_____ Relation:_____ Phone: _____

How were you referred? _____

Client grade/school or employer: _____

Form Completed by: _____

Relationship to client: _____

Patient Billing Information

(Please fill out this section if the billing address you want to use differs from your home address and or the person whom you wish to receive bills is someone other than the parent)

Name:_____

Relationship to client: _____

Home Address:_____

City:_____ State: _____ Zip Code:_____

Home phone number work or cell number: _____