Behavioral Pediatric & Family Therapy Program
Office Policy

The information in this packet is provided to assure that you have a full understanding of our office policies. Please read this carefully, ask any questions you may have, and sign where indicated. The following signatures must be secured before you can be treated in our clinic.

Financial Agreements and Authorizations for Treatment

I authorize treatment for the named person and agree to pay all fees for such treatment. I agree to pay for members of my family and for myself at the time of service unless other credit arrangements are agreed upon in writing. Charges shown on statements are agreed to be correct and reasonable unless protested in writing within thirty (30) days of the billing date.

Your signature below indicates you have received and read the information included on the following pages regarding the Behavioral Pediatric and Family Therapy Program office policies, informed consent and confidentiality statement and agree to abide by the stated terms during our professional relationship. Please read and review the following pages and keep them for your reference. Thank you for your attention to these matters.

___________________________________	___________________________________	______________
(Patient Name)	(Signature of Parent or Guardian)	(Date)

Confirmation Phone Calls

It is our practice to remind you of an upcoming scheduled appointment. Please respond to the following questions related to these automated contacts:

Please circle **ONE**: Call Text E-Mail No reminder

(Note: If no option is selected, a reminder will be made via automated telephone call)

Number for telephone call ____

Number for text message ____

Address for e-mail ____

Communication with Physician

In order to provide the highest level of care, we request permission to discuss (i.e., in person, by telephone, and in writing) relevant aspects of your case with the patient's physician(s). Please complete the following and initial the appropriate choice. If you have any questions, please discuss them with your physician or psychologist/therapist.

____

(Primary Care Physician)

_________ Yes, you may discuss relevant aspects of my or my child's case with my or my child's family physician, pediatrician, or medication prescriber.

_________ No, I do not want my or my child's case discussed with my or my child's family Physician, pediatrician, or medication prescriber