BC2 BEHAVIOR CHANGE CENTER

INFORMED CONSENT FOR TREATMENT

Confidentiality: In general, the confidentiality of all communication between a patient and psychiatrist is protected by law. Your physician can only release information about your treatment with your permission. However, there are a few exceptions.

1. Abuse and Neglect: A provider is required to breach confidentiality without a patient's permission if the provider suspects neglect. The provider is required to file a verbal and written report with the appropriate district agency.
2. Need for protective action: If it is a provider's professional judgment that you are threatening serious harm to yourself or others, a provider may notify police, warning the intended victim, or hospitalize the patient. The clear intent of these requirements is that the provider has both a legal and ethical responsibility to take action to protect endangered individuals from harm when his or her professional judgment indicates that such danger exists. Fortunately, these situations are rare.
3. Consulting with another professional: Your provider may find it helpful or necessary to consult about your case with another professional. In these consultations, the provider will avoid revealing a patient's identity. The consultant is, of course legally bound to maintain confidentiality.
4. Treatment Records and Treatment Plans: Your provider is required to maintain a record of your treatment. You have a right to review your records, request a correction, or have a copy.
5. Emergencies: In the case of any emergency immediately call 911 or go to the nearest emergency room. If you need to contact your provider for non-emergencies during office hours, email info@behaviorchangecenter.com or call the office at 703-342-9329.
6. Virtual sessions and email: BC2 provides Tele-psychiatry through video teleconferencing platforms, such as Go-to-Meeting. While BC2's connection is encrypted, your connection security cannot be guaranteed by BC2. These telepsychiatry sessions can usually be scheduled within 24-48 hours. BC2 providers also communicate through email and text messages. If you would like to use these communication methods, please acknowledge below that you understand that BC2 cannot guarantee the security of your electronic communication, and that you understand that text messages and emails are not to be used for emergency communication.

I understand the above 6 statements Signature: _____

225 Wilmington W Chester Pike
Suite 200
Chadds Ford, PA 19317

info@behaviorchangecenter.com
(703) 342-9329
www. behaviorchangecenter.com

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RELEASE OF INFORMATION

At times during your treatment, it may be beneficial for our staff to speak with family or friends. Please list those persons, if any, that you would be willing to let our staff discuss your treatment with.

Name:	
Relationship:	
Contact Phone Number:	

Name:	
Relationship:	
Contact Phone Number:	

Name:	
Relationship:	
Contact Phone Number:	

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BC2 BEHAVIOR CHANGE CENTER

FINANCIAL POLICY

Fees: There is a standard fee for our services. Payment will be collected at the time services are rendered, (credit card payment only, billed the morning of the appointment. We do not accept cash or checks). When you make an appointment, you are consenting to have the charge placed on your credit card the day of your appointment. We believe this saves you from having to discuss payment during treatment. When you are seen in the office, we want you to focus on healing, not finances.

Fees are as follows:

Initial intake - $300

Follow up - $100

Telephone calls with physician, Record Review, and Reports: Charges will be incurred for these services that require more than 10 minutes of physician time. The rate will be $50 for each 10-minute period.

Medication Refill requests: If you have missed your scheduled appointment or have not followed up as directed, you will be charged a $100 fee for refills. We have the right to refuse these requests if we feel the clinical situation dictates. We may only refill your prescription for the amount of days until the next scheduled appointment.

Appointments: It is the office policy to charge full fee for all appointments not kept or cancelled without 24 hours notice. If you must cancel your appointment, you may call the office any time day or night. If you call after hours the day and time of your call is recorded.

_____ _____ _____

Patient/Responsible Party Name Patient/Responsible Party Signature Date

_____ _____

Witness Signature Date

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CLINIC INFORMATION SHEET

PATIENT INFORMATION

Patient Name:	
Street Address:	
City, State, Zip Code:	
Date of Birth:	
Home Phone Number:	
Cell Phone Number:	
Work Phone Number:	
Email Address:	
Primary Care Physician (PCP):	
PCP Address:	
City, State, Zip Code:	
PCP Phone Number:	
PCP Fax Number:	
Emergency Contact Name:	
Emergency Contact Relationship:	
Emergency Contact Phone Number:	
Pharmacy Name:	
Pharmacy Address:	
City, State, Zip Code:	
Pharmacy Phone Number:	
Responsible Billing Person if other than self:	
Relationship to Responsible Billing Person:	

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INSURANCE INFORMATION

Primary Insurance Company:	
Policy/Identification Number:	
Group Name/Number:	
Insurance Phone Number:	
Subscriber's/Policy Holder's Name:	
Subscriber's/Policy Holder's Date of Birth:	

Secondary Insurance Company:	
Policy/Identification Number:	
Group Name/Number:	
Insurance Phone Number:	
Subscriber's/Policy Holder's Name:	
Subscriber's/Policy Holder's Date of Birth:	

In addition to the above information, **please take a copy of the front and back of your insurance card and send that along with this form** in an email to: donna.scott@behaviorchangecenter.com.

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CREDIT CARD AUTHORIZATION FORM

I, _____, authorize the use of my credit card as described below
(name as is appears on card)

for charges related to the services provided by the Behavior Change Center (BC2).

This card may be used to pay for services rendered to _____.
(name as is appears on card)

I understand that I give consent to use this card at the time that appointments are scheduled, and I will be charged for the appointment if it is not cancelled within 24 hours of the appointment time.

BILLING INFORMATION

Name of Card Holder:	
Credit Card Type: (MasterCard, Visa)	
Account Number:	
Expiration Date:	
Security Code:	
Billing Address:	
City, State, Zip:	
Signature:	
Date:	
Do you wish for your invoices to be mailed to the address listed above? (Yes/No)	
Do you wish for your invoices to be emailed? (Yes/No)	
Email Address:	

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