CORE Professional Services, P.A. Date of Service / Telehealth Disclosure

Client Name: _____ DOB: _____

Date of service discounted rates are available to individuals who do not have insurance coverage, who wish to forgo use of their insurance and pay on the date of service in order to receive the discounted rates, or are receiving a service which is non-billable to insurance. In order to receive this discount, ***services must be paid for on or before the date of service. If not, you will be billed the full fee.*** *These rates are reduced rates and are less than what will be billed to a health plan (insurance), and in order to receive these rates,* ***they must be paid for on or before you receive the service.*** By signing this form, you authorize payments to be made on your behalf. If fraudulent payments are made on your account, any fees associated with this will be assessed to you as the client.

Date of Service Discount Rates		**Full Fee (if not paid on DOS)**
Individual and Family Therapy	$85 / session	$120 / session
Psychological Testing	$100 / unit	

Service	**Rates**
Psychological Evaluation	$800 (base rate)
Assessment Component Fee	$250 per component
Travel Time	$150/60 miles of travel from home office (1 hr minimum fee)
Psychosexual Evaluation: Adult/Juvenile	$1050 (base rate + component fee)
Anger Assessment	$1050 (base rate + component fee)
Domestic Violence Assessment	$1050 (base rate + component fee)
Certification/EJJ Study without PSE	$1700
Certification/EJJ Study with PSE	$2200
Parenting Evaluation	$1050 (not billed to insurance)
Domestic Violence Inventory	$200 (does not include diagnostic assessment)
COP/Pre-employment Evaluation	$300 (not billed to insurance)
MMPI-2 Review	$200
Diagnostic Assessment/Group Intake	$150
Healthy Relationships / Sexuality Education	$400

**Please note that for each assessment component a $250 fee will be added to final price*

**If your insurance does become active as of the date of service, signing this form will allow us to bill your services to your insurance (excluding parent and travel assessments). If your commercial insurance carrier denies payment, you are completely responsible for payment in full. You understand that you can appeal this decision for nonpayment by your insurance carrier.*

Signature:_____ Date: _____
(Client or Authorized Person and Relationship)

Do you have a Health Care Directive? _____ YES _____ NO
*If no, do you wish to receive information on this? _____ YES _____ NO

Primary Care Physician: _____ Practicing Location: _____
*If you wish for records to be sent to your primary care physician, please request to sign a release of information.

Mental health services are available by two-way interactive video or audio communications, referred to as "telemedicine" or "telehealth," which means that you may be evaluated and treated by a health care provider or specialist from a different location.

1. You must inform your provider if anyone is required to be present with you at your location, and you may give your verbal permission prior to the start of a session authorizing additional personnel to be present in the room with your provider, such as another provider, intern, etc. You may request that nonessential personnel leave the room(s) at any time to allow a private consultation with your provider
2. The therapist for whom the on-site examination or treatment is performed will keep a record of the encounter in your medical record.
3. If you participate in sessions through telehealth, you understand that you must be alone in a private location for this to occur. If there is any instance of breaking confidentiality of other participants, you may be immediately terminated.
4. You are not allowed to audio record or videotape any virtual group or individual session.
5. You must participate from a location within the state lines.

Noting all the above, you understand that your participation in telehealth services is voluntary and constitutes a waiver of the usual right to physician-patient privacy and may possibly increase the risk of disclosure of your medical data. By signing this form, you acknowledge that the providers involved have explained the telehealth encounter in a satisfactory manner and that all questions that you may have about the telehealth encounter have been answered satisfactorily. Understanding the above, I consent to the telehealth process described above.

Signature:_____ Date: _____
(Client or Authorized Person and Relationship)