



**FAMILY COUNSELING ASSOCIATES (FCA)** has entered into a partnership with **CHILDREN'S MEDICAL OFFICE** to provide Psychological Services on site, alongside, and in coordination with the Pediatricians who care for your child. Because we are a separate practice, we must ask you to review and complete these materials now, in order that you be informed about the nature and conditions of the care our clinicians provide. Please direct any questions to your clinician directly.

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**Confidentiality & Protected Health Information (PHI)**

- **Communication between a patient and his or her psychologist, psychiatrist or counselor is confidential**, and we are bound by law and ethics to safeguard your information. We will obtain your authorization before disclosing PHI other than as described in this notice and if there is ever a breach of your child's PHI you will be notified.
- **Because FCA has joined CHILDREN'S MEDICAL OFFICE as part of your child's regular pediatric care** our psychologists' documentation of services provided will be an integrated part of the Pediatric record.
- **Professionals involved in your care** may seek consultation without further authorization to do so.
- **FCA will use and disclose the minimum information necessary** for treatment, billing, and healthcare operations involving your child's care at CHILDREN'S MEDICAL OFFICE.
- **If you use health insurance to pay for your care**, you have already given your permission to the insurance company to access information necessary to process claims, oversee services provided, and perform quality assurance functions.
- **If you are paying for care entirely out-of-pocket**, you have the right to restrict disclosure of PHI to your health plan, though this does not apply to out-of-pocket payment of health insurance copayments or deductibles.
- **Confidentiality as it applies to minors:** Though you will be asked to be involved in and informed about your child's progress, release of specific communications often can jeopardize a child or adolescent's willingness to be forthcoming. Though the law may allow parents the right to examine treatment records, in order to both respect the confidential nature of your child's information and facilitate the building of trust, our professional staff will ask you to agree to certain limits on the information that will be shared with you. If there is ever a concern about dangerousness, you will be notified.
- **Mental health professionals are required by law to break confidentiality under certain circumstances**, including:
  - If an individual intends to take harmful or dangerous action against another individual, we must warn the person and/or family of the person who is likely to suffer the results of the harmful behavior, as well as the local authorities, in order to protect the individual and any potential victim(s).
  - If an individual poses a danger to himself or herself, we must disclose information necessary to keep the individual safe and to facilitate appropriate treatment.
  - Suspicion of child abuse or neglect and court investigations into child abuse, neglect, custody or adoption.
  - Information regarding sexual contact between children under the age of 16.
  - Suspicion of the abuse of elders or handicapped persons.
  - In response to a court order by a judge.
  - If a patient introduces his/her mental condition as an element of claim or defense in a legal or administrative proceeding.

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Patient Name

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Date of Birth

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Patient / Guardian Signature

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Today's Date

# Family Counseling Associates, LLC

12 Essex Street | Andover, MA 01810  
360 Route 101, Suite 12B | Bedford, NH 03110  
152 Sylvan Street, Suite 12A | Danvers, MA 01923

## NEW CLIENT REGISTRATION FORM

Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Client Name: \_\_\_\_\_

Client Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Best Telephone: \_\_\_\_\_ Personal Email: \_\_\_\_\_

Parent or Guardian Name: \_\_\_\_\_

(If Applicable)

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Emergency Contact's Phone: \_\_\_\_\_

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### TREATMENT AGREEMENT

Treatment can promise great benefit and also comes with some risks. Risks can include experiencing uncomfortable levels of emotion such as sadness, guilt, anxiety or anger; and recalling and discussing unpleasant life experiences can be distressing. Prescribed medications can produce unwanted side effects in addition to the desired effects. The professionals working with you and your child will discuss with you the benefits, risks and side effects of the treatments under consideration in your child's particular case. Though there are no guarantees, the treatments we offer have been shown to benefit people and lead to reduction of symptoms, as well as improved relationships and overall ability to meet, and more successfully deal with life's challenges.

In the case of minor children, parents must provide consent for treatment. In the case of shared or joint legal custody of a child by divorced parents, the consent of one parent is required to proceed, however the other parent must not state a clear objection. If you are the parent who is bringing your child in for appointments, you will be asked for the name, address and telephone number of his or her other parent. As a routine matter, both parents will be invited to participate in your child's treatment. The exact form and frequency of such contacts will be determined on the basis of need as assessed on a case-by-case basis. Should one parent object, we cannot proceed with treatment until the objection is withdrawn or overruled on by the court. You have the right to revoke this consent at any time, in writing. Notice of revocation of consent will be considered effective on the date received.

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Date of Birth

Patient / Guardian Signature

Today's Date

# Family Counseling Associates, LLC

## FINANCIAL AGREEMENT

I attest that I have requested mental health services with FCA, LLC. Please check the appropriate selection:

I will utilize my health insurance for service. I authorize the office of Family Counseling Associates, LLC to bill my health insurance carrier on my behalf.

I will self-pay for service at a rate of \$\_\_\_\_\_ per session.

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## NOTICE OF PRIVACY POLICY

My signature below indicates that the "Notice of Privacy Practices" was available for my review, and is also available at [www.fca-NE.com](http://www.fca-NE.com). I am aware that I can also ask my clinician for a paper copy. I understand that I may ask questions about the information outlined in the Notice at any time in the future.

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## COMMUNICATION CONSENT

I give permission to FCA to contact me at the phone number(s) or email listed on this Client Registration Form. If I am not available, I authorize Family Counseling Associates to leave a message on my voicemail. My signature below indicates that I am aware that the "Electronic Communication Policy" is available for my review at [www.fca-NE.com](http://www.fca-NE.com). I am aware that I can ask my clinician for a paper copy.

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Patient Name

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Patient Date of Birth

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Patient / Guardian Signature

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Today's Date

# Family Counseling Associates, LLC

Initial Evaluation	\$175 per 50-60 minute session
Individual	\$140 per 45-50 minute session
Couples and Families	\$160 per 50-55 minute session

## **SERVICES NOT COVERED BY INSURANCE**

Written Report or Letter	\$75 per page
School Conferences	\$200 per hr. (plus travel time)

### **Telephone / Email Communication:**

Telephone and email communication with your clinician is not covered by insurance. There is no charge for brief, routine phone calls or emails (less than 10 minutes) between a client and their clinician to discuss scheduling, billing, or brief progress updates. However, longer correspondences between a client and clinician, as well as all collateral correspondences, will be billed at a rate of \$25 per 15 minutes. This fee also applies to all paperwork clinician's complete on behalf of clients. \_\_\_\_\_(initial)

### **Cancellations / No-Shows:**

A 24-hour advance notice is required for all cancellations. No-shows and late cancellations (less than 24-hour notice) will result in a fee of \$70 which is payable before subsequent sessions can be scheduled. *This fee is not covered by insurance.* \_\_\_\_\_(initial)

### **Payment Policy:**

All session payments and copayments are to be made at the time of each visit. Statements of balance will be sent out at the end of each month. Payment in full is due within 30 days unless an alternate agreement is made in advance. All delinquent accounts will be sent to collections. \_\_\_\_\_(initial)

### **Insurance:**

Notify us immediately of any changes to your health insurance coverage. It is your responsibility to keep your medical insurance information updated. Clients will be responsible for paying all claims that are not reimbursed by their insurance company due to changes to, or termination, of their policy. Family Counseling Associates, LLC does not submit secondary insurance claims, or Worker's Compensation claims. \_\_\_\_\_(initial)

### **Sliding Scale / Reduced Fee:**

We offer a reduced fee schedule. Please contact us for more information. \_\_\_\_\_(initial)

### **Billing Terms**

I understand that services provided by FCA are charged separately to your health plan by FCA, and are subject to all of the provisions of your plan's coverage of Behavioral Health Care, including separate copayments. \_\_\_\_\_(initial)

# Comprehensive MedPsych Systems Billing Services



## Introduction Letter

Family Counseling Associates has recently partnered with CMPS Billing. CMPS is a mental health billing organization located in Sarasota Florida. We have been in business since 2000. Our goal is to provide Family Counseling Associates' patients support with all billing and insurance claims related matters. We have a team of certified medical coders and billers with over 100 years of combined experience.

CMPS billing is passionate about what we do, and we hope to be a support to Family Counseling Associates' clients!

What does this mean for you? We are here to help!

You will notice a few changes in the near future as we work to get account statements and billing information out to you in a timely manner. You may receive statements from us, and we may be contacting you regarding balances or insurance questions. In a few weeks, we will have set up a portal where all of your billing and forms will be located. You will be able to log on and view your information or pay an outstanding balance. This helps to make our communication efforts quick and easy for you and your provider. We will send out another letter to you before this goes into effect. We want to provide compassionate, patient-centered care for all.

We are looking forward to working with you!

Please do not hesitate to contact us with any inquiries or billing questions at: **(877) 299-5426 Option #4.**

Sincerely,

Comprehensive MedPsych Systems Billing Services