Daniel B. Goldman, Ph.D., LLC 5971 Cattlemen Lane, Sarasota, FL 34232
Licensed Psychologist (FL PY8470) T: (941) 444-5578 F: (941) 444-5592

INFORMED CONSENT FOR TREATMENT and FINANCIAL AGREEMENT

CONFIDENTIALITY

See *Florida Notice Form for the Health Insurance Portability and Accountability Act* provided.

CONFIDENTIALITY REGARDING MINORS AND PARENTS

The law may allow parents to examine a child's treatment records when the child is a patient under 18 years of age who is not emancipated. Privacy in psychotherapy is often crucial to successful progress. Thus, before giving parents any information, Dr. Goldman will discuss this with the child, if possible, and do his best to handle any objections that the child may have. If Dr. Goldman believes that a child is in imminent danger or is a danger to someone else, he will notify the child's parents of this concern.

*** Initial _____**

EMERGENCIES

Daniel B. Goldman, PhD, LLC operates during traditional business hours and **does not offer 24-hour availability, crisis coverage, or emergency treatment**. As such, Dr. Goldman may be unavailable in the case of an emergency. If you should experience a crisis, you should call 911, go to your local hospital emergency room, or contact the 24-hour crisis stabilization unit at Coastal Behavioral Healthcare (941-364-9355).

*** Initial _____**

INSURANCE / BILLING POLICIES

Dr. Goldman is a provider for some, but not all, insurance companies. In checking your benefits, he uses a private billing contractor who uses tools provided by insurance companies. The benefit information received from your insurance carrier is advisory only and not a guarantee of coverage or payment. If Dr. Goldman is a provider for your insurance, you will be required to pay any copays or deductibles owed at the time of your visit. All patients are responsible for charges not covered by insurance which are allowable by contract and by law (Medicare patients are advised that Medicare pays for 80% of the allowable Medicare rate. Medicare recipients are responsible for paying the remaining 20% if they do not have a secondary insurance that covers that amount). Your insurance carrier will initially be billed for the full fee, and once payment is received from your carrier, the fee will be adjusted to the contracted rate. If Dr. Goldman is not a provider for your insurance carrier, he will offer to submit a claim as a courtesy to assist you in receiving any out of network benefits. In such case, you will be required to pay Dr. Goldman's full fee until such time as her receives payment from your insurance carrier; any overpayments will then be counted toward payment of future sessions or refunded to the patient. The amount you pay depends upon the length of the session and upon your insurance. Dr. Goldman's fees are $175.00 for initial evaluations, $160.00 for 50-minute therapy appointments, and $80 for 30-minute therapy appointments. By initialing below, you give permission for Dr. Goldman or a private billing contractor, billing on behalf of Dr. Goldman, to send required information to your insurance company or EAP. You agree to place your signature on file, and that you will be responsible for any unpaid balance such as co-pays, deductibles, and non-covered services. After 90 days of no response, the billing service has the option of turning the account over to a collection agency.

*** Initial _____**

Dr. Goldman will not provide evaluations or endorsement statements for the purpose of securing special benefits (e.g., Social Security disability, disability insurance policies, emotional support animals, service animals, etc.). If you anticipate needing a doctor to evaluate or endorse you for special services, please discuss this with Dr. Goldman before your first session.

*** Initial _____**

Continued on next page

CANCELLATIONS AND MISSED APPOINTMENTS

In the event that you need to reschedule or cancel an appointment with Dr. Goldman, he can accommodate you with **AT LEAST 48 HOURS NOTICE.** When you make an appointment with a Dr. Goldman, you are paying not only for his services but also for his time. As a one-time courtesy, you will not be charged for the first missed appointment or late cancellation. Thereafter, you will be charged a fee ($100/hour; $50/half-hour) for subsequent missed appointments or cancellations made with less than 48 hours notice. If you use health insurance benefits for your therapy, be advised that your health insurance will not pay for missed or cancelled appointments. As such, you are solely responsible for the fee for missed appointments.

*** Initial _____**

INSURANCE AND RELEASE OF INFORMATION

If you are using insurance, your contract with your health insurance company requires that Dr. Goldman provide certain information relevant to the services you receive. Dr. Goldman is required to provide a clinical diagnosis and sometimes additional clinical information including, but not limited to, treatment plans, summaries, or your complete medical record. By signing this agreement, you authorize Dr. Goldman to provide requested information to your health insurance carrier. You always have the right to pay the full fee for Dr. Goldman's services to avoid the disclosure of any information to your insurance company (unless prohibited by your insurance contract).

*** Initial _____**

LEGAL MATTERS

If Dr. Goldman is subpoenaed or court-ordered to provide testimony or records by any party in a legal matter in which you are involved, you are responsible for payment for time spent preparing for legal matters; travelling to/from legal settings; waiting to be called into legal settings; and in legal settings. His fee is **$350.00 per hour** for preparation and attendance at legal proceedings. A predetermined block of time will be set aside for the day of the legal proceedings. Payment for the time block is required 10 days in advance; must be paid in the form of a credit card or cashier's check; and no partial or full refunds will be given for paid time that goes unused.

*** Initial _____**

CONSENT TO TREATMENT

I consent to mental health services. I authorize Daniel Goldman, Ph.D., or a private billing contractor on his behalf, to bill my medical insurance and to release any information necessary to file a claim in order to be paid for services provided. I consent that Dr. Goldman may receive payment from my insurance carrier for any services he renders to me and I agree to pay for any amounts not paid by my insurance, including the fees stated above for no-shows and cancellations occurring with less than 48 hours notice. I understand that I have the right to refuse or terminate treatment at any time. I understand that my treatment will be considered terminated after 30 days without contact with Dr. Goldman, but that I can return for treatment in the future if Dr. Goldman has availability.

My initials above and my signature below certify that I have read and understand the information in this document, that I accept all specified terms and fees therein, that I have received answers to any questions I may have, and that I have received information on patient rights and the Health Insurance Portability and Accountability Act.

_____ _____

Patient Signature Date

_____ _____

Legal Guardian if patient is a minor Date

You may revoke this agreement in writing at any time. Such revocation will be binding unless (a) Dr. Goldman taken action in reliance on it; (b) there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy; or (c) you have not satisfied financial obligations you have incurred.