**CONFIDENTIALITY**

All information between Doctor and patient is held strictly confidential **unless:**

1. The patient authorizes release of information **with** his/her signature;
2. The patient presents a physical danger to self;
3. The patient presents a danger to others;
4. Child/Elder abuse is suspected.

In cases 3 and 4, we are required by law to inform potential victims and legal authorities so that protective measures can be taken.

**FINANCIAL TERMS**

Upon verification of health plan/insurance coverage and policy limits, your insurance carrier will be billed for you and your Provider will be paid directly by the carrier. The patient will be responsible for any applicable deductibles and co-payments. If you are not eligible at the time services are rendered, you are responsible for payment. For those patients without health plan/insurance coverage, payment arrangements are to be made prior to your first visit.

**CANCELLED/MISSED APPOINMENTS**

A scheduled appointment means that time is reserved only for you. If an appointment is missed or cancelled with ***less than 24 hours notice,*** the patient will be billed according to the scheduled fee of **$125.00**.

**APPEALS AND GRIEVANCES**

I acknowledge my right to request reconsideration in the case that outpatient care (number of visits) is not authorized (Appeal). I understand that I would request an Appeal through my Provider and that I risk nothing in exercising this right. I also acknowledge that I may submit a Grievance to the Provider or Clinical Group Administrator at any time to register a complaint about any aspect of my care. If I am not satisfied with the response I receive, I may submit the Grievance directly to VBH.

**CONSENT FOR TREATMENT**

I further authorized and request that Dr. Boris Khaimov carry out psychological examinations, treatments and/or diagnostic procedures which no or during the course of my care as a patient are advisable. I understand that the purpose of these procedures will be explained to me upon my request and subject to my agreement. I also understand that while the course of therapy is designed to be helpful, it may at times be difficult and uncomfortable.

**RELEASE OF INFORMATION**

I authorize the release of information for claims, certifications/case management/quality improvement and other purposes related to the benefits of my Health Plan. Releases of information to providers, family or anyone other than the above mentioned, requires a separate form.

***I understand and agree to all of the above information.***

_____ _____

Patient Name (Please Print) Witness (Signature)

_____ _____

Patient/Parent or Guardian Signature
(If patient is under the age of 18, a parent or guardian must sign for consent).

Date