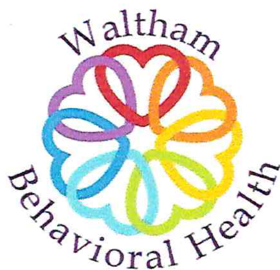

210 Bear Hill Road
Waltham, MA 02451
T: (781) 966.0070
F: (781) 915.0755

TREATMENT AGREEMENT

Treatment of Adults: During a medical evaluation or ongoing treatment, your prescriber may recommend psychotherapy as a part of your treatment plan.

Treatment of Minors (under the age of 18): All patients under the age of eighteen (18) must be accompanied by a legal guardian during their first visit. A parent/guardian is required to authorize the treatment of minors. ***Waltham Behavioral Health, LLC (WBH) will not undertake treatment of minors without parental consent.*** A parent, guardian or any other adult accompanying a minor for treatment are responsible for that child and all costs associated with their treatment. In the treatment of minors, parents/guardians have a right to access and authorize the release of medical information. A child has a right to confidentiality with their provider with the exception of information that infers danger to the child or others. When a minor patient turns eighteen their treatment, information and records revert to their control.

Confidentially: Information regarding your care here is entirely confidential. No information will be provided to a third party unless we have your written authorization for its release. In rare cases we are required by law to disclose confidential information including situations of known or suspected child abuse, elder abuse or likelihood of harm to yourself or specifically identified individuals.

Grievance Procedure: As a WHB patient you have the right to register dissatisfaction. The facility is open to recommendations and will respond to complaints. Complaints should be registered with your therapist or provider. However, if this is not possible or acceptable, you may communicate your grievance directly to the WBH Practice Manager. *You will never be penalized for filing a complaint.*

Request for Medical Records: Medical records can be obtained for an administrative fee of $25. This fee covers the full administrative costs incurred for this process. It may take up to seven (7) days from the date of the request to receive your records.

Declaration of Agreement Regarding Payment and Missed/Cancelled Appointments:
By signing below, I understand and agree to the following:

- All co-payments are due at the time of treatment
- **Reminder calls/texts are a courtesy:** I am responsible for knowing the dates/times of my appointments regardless of receipt of a reminder call or text
- If I am unable to keep an appointment I must notify WBH at (781) 966-0070 as soon as possible and **no fewer than 24 hours prior to the scheduled appointment**
- In the event of a missed appointment or failure to cancel with 24 hours' notice, I agree to pay a **$75 late cancellation fee**
- Repeatedly missing or cancelling appointments without adequate notice may result in discharge from the practice
- A fee of $25 will apply to all returned checks

Signature: ____ **Date:**___________________________

Waltham Behavioral Health

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Patient Information Form

(Please print)

Patient Name: (Last, First, Middle):______________________________

Responsible Party (if patient is a minor):______________________________

Date of Birth:____________________ Age:__________ Gender:_______

SS#:__________________________

Cell Phone:____________________ Home/Work Phone:____________________

Email: ______________________________@______________________________

Primary Care Physician's Name:______________________________

Address:______________________________

Phone:______________________________

Local Pharmacy Name:______________________________

Address:______________________________

Phone:______________________________

Mail Order Pharmacy Name:______________________________

Address:______________________________

Phone:______________________________

Referral Source: _______Alt. Provider _______Insurance _______Patient _______PCP
_______School _______Our Website _______Other

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Financial Policy

We are committed to providing you with the best possible care and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, policies or any costs for which you may be responsible.

- For patients with insurance we are contracted with: **all copays, deductibles and co-insurance are due at the time of service**
- For patients with non-contracted insurance or no insurance: **full, out-of-pocket payment is due at the time of service**
- If your insurance company requires a referral from your primary care physician, the referral must be in place by the date of service: **without this referral in place, your appointment will need to be rescheduled**
- We accept cash, personal checks and all major credit cards

Treatment may be denied for the following reasons:

- A referral is not obtainable when required by the patient's insurance
- A patient has been delinquent of back payments and/or the account has been sent to a collection agency
- A patient has missed more than three previous appointment and has been advised of being denied another appointment
- A minor under eighteen is unaccompanied by an adult

I,______________________________, have read and understand the conditions for payment to Waltham Behavioral Health, LLC as outlined above.

I hereby authorize WBH to apply for benefits on my behalf for covered services rendered by them, or their order. I request that payment from my insurance company and/or attorney from PIP benefits or settlements proceeds, be made to WBH.

I understand that my insurance carrier may require a referral from my primary care physician as authorization for treatment and, if so, **it is my responsibility to obtain this referral**. If a claim is denied to my insurance carrier for failure to obtain a referral, I will be held responsible for the full balance of the claim.

I permit a copy of this form to be used in the place of the original.

Signature:____________________________________ Date:____________________

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Unpaid Accounts Policy

Our office will make every effort to communicate with you regarding your account and will present reasonable options for payment. In the event a bill goes unpaid for 60 days you will be charged interest on your account balance. Additionally, if a bill goes unpaid and you do not contact our billing department to discuss payment options, or if you do not satisfy your account balance for 90 days, the account will be turned over to a collections agency.

Patient Name:____Date:_____________

Signature:_________________________________Parent/Guardian:______________________

Prescription Refill Policy

If you have missed/cancelled your last appointment, you may be subject to a $25.00 prescription refill charge if a prescription is needed prior to you next scheduled appointment. This is a processing fee which can occur at the discretion of the provider on call.

Patient Name:____Date:_____________

Signature:_________________________________Parent/Guardian:______________________

Medical Records Policy

It is our policy to obtain any past medical/psychiatric records to ensure comprehensive and collaborative care. If a patient does not consent below, he/she will be referred to another facility.

I, ___________________________, consent to WBH requesting past medical/psychiatric records from previous providers.

Signature:_______________________________________ Date:___________________