*BE-Care Registration Form*

Psychology Consultation Specialists, PLLC

Date_____

*Child's Information*

Patient Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Gender: Female Male Date of Birth: _____ Age: _____

Parent 1 Name: _____ Phone(s) (Cell): _____

Parent 2 Name: _____ Phone(s) (Cell): _____

Parent Street Address (if different): _____

City: _____ State: _____ Zip: _____

*Responsible Party* (if different than the patient)

Name: _____ Relationship: _____

Address: _____

The undersigned hereby acknowledges that she/he has been informed that BE-Care is an educational service and therefore not covered by insurance. Therefore, the undersigned agrees that he/she will bear full responsibility for payment of all charges for BE-Care.

_____ _____ _____

Responsible Party Signature Relationship Date

info@pcsmn.com
www.pcsmn.com

PSYCHOLOGY CONSULTATION SPECIALISTS PLLC
CHILD | TEEN | FAMILY | ADULT

763.559.7050
3300 Fernbrook Lane N, #120
Plymouth, MN 55447

# BE-CARE OUTPATIENT SERVICES CONTRACT

Welcome to Psychology Consultation Specialists, PLLC. This document contains important information about our professional services and business policies. When you sign this document, it will represent an agreement between you and Psychology Consultation Specialists, PLLC.

I understand:

- Behavioral Express Care (BE-Care) involves brief intake, educational and recommendation services for children, adolescents, and their families regarding emotional, behavioral, and psychosocial concerns. The purpose of this service is to provide quick, easy, and affordable access to mental health education. The typical Be-Care appointment is 30 minutes, during which psychologists will meet with families (parents and/or children) to discuss the concerns and provide support, recommendations, and outside referral options (if needed).

- The standard fee for BE-Care is $25.

- CANCELLATION POLICY: If you cancel an appointment and do not provide at least 24 hours notice, you will be charged the full fee for your appointment.

- BE-Care is an educational service and not covered by your insurance. Payment is due at the time of service and can be made with a check, cash, or credit card.

- If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, we have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through the courts. If such legal action is necessary, its costs will be included in the claim.

- Any checks returned to the office are subject to an additional fee of $25.00.

BE-Care is being requested for _____

By signing this consent for treatment, I fully understand and accept the terms of this consent.
I acknowledge that I have been provided with a copy of the Notice of Privacy Practices, which describes uses, disclosures, and rights of my protected health information.

_____ _____ _____ _____

(Signature of Patient) Date (Signature of consenting party, if other than patient) Date

_____

(Relationship to patient)

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# BE-Care Payment Form

The $25 fee for this BE-Care appointment is due at the time of service. BE-Care is an educational service that is not covered by your insurance.

Patient Name: _____

Payment Method:

Cash

Check

Credit Card Payment: Visa MasterCard Discover

_____ _____ _____ _____
Credit Card Number

_____ _____ _____
Expiration Date CVC Code Billing Zip Code

_____
Cardholder Signature

info@pcsmn.com
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## AUTHORIZATION FOR RELEASE AND EXCHANGE OF CONFIDENTIAL INFORMATION

**THIS WILL AUTHORIZE PSYCHOLOGY CONSULTATION SPECIALISTS, PLLC TO BOTH RELEASE TO, AND OBTAIN FROM:**

Partners in Pediatrics _____ _____
(Name of provider) (Address)

_____ _____
(City/state) (Phone/fax)

**THE FOLLOWING INFORMATION:**

Medical Records _____
Psychological Assessment _____
General Communication _____

**Applicable dates:** _____

**The purpose of this information is for assessment and treatment planning. *This authorization for release and exchange of confidential information is valid for one year from the signature date.***

**FROM THE RECORDS OF:**

_____ _____
(Name of Patient) (Date of Birth)

_____
(Address)

**I understand:**

- **That I have the right to inspect and copy the information disclosed.**
- **That I may cancel this authorization in writing at any time. Stopping this authorization will not apply to information that has already been released or disclosed.**
- **That this authorization shall expire without my express revocation one year from the date provided below.**
- **That any disclosure of information carries with it the potential for re-disclosure and the information may not be protected by federal privacy rules.**
- **That my psychologist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.**

_____ _____
(Signature of patient or parent/authorized legal guardian) (Date)