Client Information and Services Agreement Form

Rachael Llewellyn, M.S., BCBA

Client Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Responsible party (if other than client): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Confidentiality and Records:** As a Board Certified Behavior Analyst at the Monocacy Start Center, I offer services without regard to age, race, gender, or religious affiliation. While I may discuss you or your child’s care with other treating providers at Monocacy Start Center in order to provide you with the most comprehensive care possible, I will not discuss treatment or release information outside of Monocacy Start Center without your written permission. I keep secure records of treatment as required by the State of Maryland. **Note: state law limits confidentiality and we are mandated to report any suspected child/elder abuse or harmful intentions. We also are required to make reasonable efforts to keep our clients safe if they become suicidal.**

## Acknowledgement of Receipt of HIPAA Regulation Notice from Monocacy Start Center: I, the undersigned, hereby acknowledge that I have read and understand all parts of Monocacy Start Center’s notice of privacy rights under HIPAA regulations. I understand all terms outlined in the document. By signing this form, I understand my rights as a patient and the provider’s duties as a mental health provider under HIPAA regulations. Furthermore, I understand that a copy will be provided to me at my request.

**Fees and Services:**

Consultation (in person, on phone, or electronic) $150.00 per hour

Behavior Therapy and Treatment Planning $150.00 per hour

Assessment Review $150.00 per hour

Record Retrieval $ 10.00 per request

Photocopy Charge for Prior Records (if requested) $ 0.15 per page

**Payments and Insurance Coverage:**

Sessions canceled with less then 24 hours advance notice will be charged a $75.00 no show fee. Charges for late cancellations or missed appointments will be solely the responsibility of the client. Insurance will not cover such expenses. In addition, it is our policy that frequent missed appointments may result in discontinuation of treatment.

Payment is expected at the time service is rendered. For services covered by insurance, Monocacy Start Center will submit on the client’s behalf, and accept assignment of insurance payment. For in-network services, client is responsible for the allowed portion of charges not paid for by insurance. For out of network services, client is responsible for charges not paid by insurance. If preauthorization is needed, Monocacy Start Center will complete required treatment request forms.

Charges shown by statements are agreed to be correct and reasonable unless protested in writing within 60 days of billing date. Balances over thirty (30) days past due will be charged interest at the rate of 1% per month. Treatment may cease if payment is not made in a timely manner. Clients are responsible to pay for services rendered, including reasonable attorney’s fees and costs of collection in the event of default.

**By signing below:**

I/we demonstrate that I/we understand and agree to the above policies and agree to pay for all fees and charges

I/we certify that I/we have the legal right to do so and hereby authorize Monocacy Start Center to provide assessment and treatment for my child

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*Child’s full name and date of birth*

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First Responsible Party’s Printed Name Date First Responsible Party’s Signature Date

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Second Responsible Party’s Printed Name Date Second Responsible Party’s Signature Date