TREAT NYC
Psychology Therapy Services PLLC

211 W 88th Street
New York, NY 10024
Phone: (212) 222-7477
Email: admin@treatnyc.com

TREATMENT CONSENT FORM

Please read and sign at the end stating you fully understand and consent to the information below.

SERVICE OFFERED

Please check the box for the appropriate service below.

- ☐ Neuropsychological Testing
- ☐ Individual Therapy
- ☐ Child Therapy
- ☐ Group Therapy
- ☐ Family Therapy
- ☐ Parent-Child Dyadic Therapy
- ☐ Parent Coaching
- ☐ Couples Therapy

APPOINTMENTS AND CANCELLATIONS

Appointments are scheduled on a weekly basis; individual sessions are 45 minutes long. More frequent sessions are available if you and your therapist decide this would be useful. If you must cancel or reschedule your appointment, we ask that you call or email your therapist **at least 2 business days** in advance. Cancellations that occur with less than 48-hour notice or failure to attend an appointment **will be charged the full fee** for the session.

FEES AND PAYMENT

Payment for services is due **within 10 days** of receipt of bill, typically issued monthly. Cash or check payments are preferred; however, special arrangements to pay by credit card can be made.

Please indicate your agreed upon fee per session: _____

INSURANCE

Treat NYC takes a very limited number of insurance policies. **If your therapist has told you that she/he is in-network for your plan, please be sure to email your insurance information, including copies of both sides of your insurance card, to** admin@treatnyc.com.

If you will be self-paying or submitting your monthly bill for out-of-network coverage, then you are responsible for paying the full amount included on your monthly bill within 10 days of receipt of bill (as described above).

Please be aware that if your insurance coverage changes and you would like to begin using in-network coverage, your therapist must be notified in writing before the coverage can begin. All necessary insurance information must also be provided. Prior to our receipt of your written notice and insurance information, you will remain financially responsible for paying session fees at the level previously set.

CONFIDENTIALITY

The security of your child's sensitive information is of utmost importance, and we are bound by law to protect your child's confidentiality. Any disclosure of your child's treatment to others will require your explicit written consent. All email correspondence with @treatnyc.com accounts are encrypted and confidential. However, we cannot guarantee total confidentiality for text message exchanges.

There are exceptions to this confidentiality, where disclosure is mandatory. These include the following: If there is a threat of immediate harm to your child, your therapist is required to seek hospitalization when necessary, and will likely seek the aid of family members or friends to ensure your safety; If there is a threat to the safety of others, your therapist will be required by law to take protective measures including seeking hospitalization; In legal hearings, you do have the right to refuse your therapist's involvement in the hearing, however, there are rare circumstances in which your therapist might be required by a judge to testify on your child's emotional, or cognitive condition. If you do not want this to occur, Treat NYC will fight to preserve your child's confidentiality and oppose clinical disclosures within the legal limits of the law.

These situations rarely occur in an outpatient setting. If they do arise, your therapist will do their best to discuss the situation with you before taking action.

TREATMENT CONSENT

By signing below, you certify that you have read and understand the terms stated in the Treatment Consent Form. You indicate that you agree to abide by the terms stated above during the course of our therapeutic relationship.

Parent/Guardian name (PRINT): _____ Date:_____

Parent/Guardian signature: _____

Therapist name (PRINT): _____ Date:_____

Therapist signature: _____