

BE-Care Registration Form

Pediatric Consultation Specialists, PLLC

Date _____

DX Code _____

Therapist _____

Child's Information

Patient Name (Print) _____ Date of Birth _____

Street Address _____ Last Name _____ First Name _____ Initial _____ Home Phone () _____

City _____ State _____ Zip _____

Gender: Female Male Age _____

Parent 1 Name: _____ Phone(s) (H/W/C): _____

Parent 2 Name: _____ Phone(s) (H/W/C): _____

Parent Address (if different): _____ City _____ State _____ Zip _____

Responsible Party (if different than the patient)

Name _____ Relationship _____

Address _____ Phone () _____

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



Pediatric Consultation Specialists, PLLC
Behavior ★ Learning ★ Success

BE-CARE OUTPATIENT SERVICES CONTRACT

Welcome to Pediatric 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 Pediatric 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

(Signature of Witness)

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

Exp: ____ / ____ _____ _____

Billing Zip Code

Signature of Cardholder



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AUTHORIZATION FOR RELEASE AND EXCHANGE OF CONFIDENTIAL INFORMATION

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

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

(City/state/zip) (Phone/fax)

THE FOLLOWING INFORMATION: **Applicable dates:** _____

Medical Records _____	School Records _____
Speech/Language Evaluation _____	Achievement Testing _____
Psychological Assessment _____	Teacher Rating Scales _____
Psychiatric Evaluation _____	504 Plan or IEP _____
Physical Therapy _____	Progress Reports _____
Occupational Therapy _____	Other: _____

The purpose of this information is for assessment and treatment planning.

FROM THE RECORDS OF:

(Name of Patient) (Address)

(Phone/Fax) (Date of Birth)

I understand that I have the right to inspect and copy the information disclosed and the right to withdraw this authorization at any time, but this authorization shall expire without my express revocation one year from the date provided below. Further disclosure by the receiving party is prohibited. I understand 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)

(Signature of witness) (Date)