UPDATED December 2023

AUSTIN BEHAVIORAL HEALTH CENTER, L.C.
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512-347-7666

APPOINTMENTS

Appointments are usually scheduled on a weekly basis, but we will attempt to schedule your appointments at the frequency that is best for your situation. **Each initial visit requires a $175 non-refundable deposit (unless you cancel within seven days) at the time of scheduling and is applied to the cost of the appointment**. If a scheduled appointment must be changed, please contact the office at least 48 hours in advance, weekends included. Confirm scheduled or canceled appointments with the front desk. Since your appointment time has been reserved for you, **WE DO CHARGE FOR APPOINTMENTS NOT CANCELED AT LEAST 48 HOURS IN ADVANCE. YOU ARE RESPONSIBLE FOR THE FULL FEE.** Your insurance company will not pay for appointments you fail to keep. Of course, this procedure does not apply in an emergency.

PSYCHOLOGICAL TESTING

Psychological testing typically requires 3-6 hours per session. It is very difficult to fill these times when clients cancel on short notice. Therefore, **we require seven days' notice if you need to cancel or reschedule your appointment. Appointments for psychological testing require a $275 non-refundable deposit (unless you cancel within seven days) and is applied to the cost of the evaluation.** If you fail to keep your appointment or cancel your appointment without adequate notice (seven days) the deposit cannot be refunded or applied to future testing. Full payment for psychological testing is due at the first assessment session.

EMERGENCIES

In case of emergencies, we may be reached through the office. The number is 512-347-7666. Please make it clear to the person who takes the message that this is an emergency or urgent call. If we are out of town or away from a telephone, another Mental Health Professional will be taking our calls, or you will be provided with a cell number.

PAYMENTS

For children, the initial assessment consists of one 1.5-hour session ($350.00); or one 50-minute initial visit ($250.00) and one 45-minute parent follow-up visit ($220.00). For adults, the initial session consists of one 50-minutes session ($250.00). Thereafter, individual sessions are ($220.00). Psychological Testing is billed at ($235.00) per hour for children six and younger. The cost for a full battery for those seven and older is $2350.00. Testing fees are based on administration time, plus time for scoring, interpreting results, writing the report, and the feedback appointment. Two weeks after the testing is completed, we will meet with you to review the results of the evaluation and go over the report. All clients will receive a detailed report during the feedback session.

Payment is due at the time of your appointment. In some cases, a double session, an hour and a half, will be scheduled. **Telephone calls of over 10 minutes will be charged at the same rate as office sessions.** There will be no charge for business calls of less than 10 minutes. Case management, reviews with insurance companies, and completion of forms are billed in fifteen-minute increments, at our hourly rate ($235.00).

INSURANCE

Some major insurance companies will pay a portion of the cost of psychotherapy and psychological testing after you have satisfied your deductible. Your insurance payments go directly to you. An itemized statement of your account will be provided, upon your request, at the time of each session. **Payment is always required at the time of service, even when using insurance.** You are responsible for all services.

If a claim is filed with your insurance company, they will access confidential information about you. This may include diagnosis, treatment plan, and any other information they determine is relevant. Managed care companies and some PPOs often require this information prior to initiation of treatment and seek to involve themselves in the management of your treatment.

NOTE: SERVICES FOR CUSTODY EVALUATIONS, LEGAL CONSULTATIONS OR OTHER TYPES OF FORENSIC SERVICES MAY NOT BE REIMBURSED BY YOUR INSURANCE COMPANY. CLIENTS ARE RESPONSIBLE FOR THE ENTIRE FEE AND A RETAINER IS REQUIRED.

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND AGREE TO THESE CONDITIONS.

Signature **Printed Name** **Date**

PLEASE CONTINUE TO NEXT PAGE

PARENTS/GUARDIANS

I have the legal right to obtain psychological services for my child. ☐YES ☐NO

Signature Printed Name Date

Please list the names of any other adults that have the legal right to obtain psychological services for your child or the right to confidential information about your child:

Parents/Guardians are:

☐ Married ☐Separated ☐Divorced ☐Never Married

*If parents/guardians do not live together, please provide a copy of a court order or divorce agreement that indicates your right to obtain treatment for your child, ***or*** a signed and dated letter from the second parent authorizing treatment.

I understand that children benefit from confidentiality when they participate in therapy. I also understand that confidentiality does not exist when there is a danger to self or others.

Signature Printed Name Date