Network Biofeedback Services ~ Unlock Your Mind
Biofeedback, Mental Health Counseling & Creative Arts Therapy, PLLC
Clinical Director: Susan E. Antelis, MPS, LMHC, LCAT, BCB, BCN

LIMITS OF CONFIDENTIALITY

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

_____

Duty to Warn and Protect When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Minors/Guardianship Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Insurance Providers (when applicable) Insurance companies and other third-party payers are given information that they request regarding services to clients. *Information that may be requested includes, but is not limited to: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries.

I agree to the above limits of confidentiality and understand their meanings and ramifications.

_____ **Client**

Signature (Client's Parent/Guardian if under 18)

_____

Today's Date

211 Broadway, Suite 207 Lynbrook, NY 11563 *nybiofeedback@gmail.com*
Phone/Fax: 516-825-6567 *www.nybiofeedback.com*
www.networkbiofeedbackservices.com

Network Biofeedback Services ~ Unlock Your Mind
Biofeedback, Mental Health Counseling & Creative Arts Therapy, PLLC
Clinical Director: Susan E. Antelis, MPS, LMHC, LCAT, BCB, BCN

CANCELLATION POLICY & FEES AGREEMENT

Your appointment time is reserved for you. If you fail to cancel a scheduled appointment, you will be billed for your missed appointment. A **cancellation fee of $50** is charged for missed appointments or cancellations with less than a 24-hour notice unless it is due to illness or an emergency.

A bill will be mailed directly to all clients who do not show up for, or cancel an appointment. Thank you for your consideration regarding this important matter. There is a **$50 fee charged for returned checks**, in which case, the session is then to be paid by cash or credit.

For clients who have insurance coverage or reimbursement: we **cannot and will not charge your insurance company for the missed session.** You will be responsible for the cancellation fee. In addition, **if your insurance company fails to pay us for your regular sessions, you agree to pa**y for your sessions in full at our regular fee rates. That information will be shared with you upon request.

We value your time and resources and that is why we ask you to agree to do the same. **Thank you** for your faith in us; it is our pleasure to offer our services to you and your families.

By signing this form, I hereby agree to honor the above:

_____ **Client Signature**

(or Client's Parent/Guardian if under 18)

_____

Today's Date

211 Broadway, Suite 207 Lynbrook, NY 11563 *nybiofeedback@gmail.com*
Phone/Fax: 516-825-6567 *www.nybiofeedback.com*
www.networkbiofeedbackservices.com