Seven Dean Street Taunton, Massachusetts 02780 Telephone (508) 822-0006
(508) 822-1690
Telecopier (508) 880-5389
Email ABHLLC@verizon.net
Website: ABHLLC.net

ASSOCIATES IN BEHAVIORAL HEALTH, LLC

Psychology and Neuropsychology
John R. Stahl, Ph.D., ABPP
Jacqueline F. Stahl Selines, PsyD
Rebecca Uth, PsyD

Clinical Social Work
Jennifer Costello, LICSW
Stacy Magee, LICSW
Paul C. Stone, LICSW
Anne B. Terry, LICSW

Mental Health Counseling
Lisa M. Forman, LMHC
Peter W. Ham, LMHC
Lyseloht Pagan-Morales, LMHC
Jean C. Pegg, LMHC
Matthew Selines, LMHC

CONSENT TO EVALUATION AND TREATMENT AND AUTHORIZATION TO RELEASE INFORMATION

I understand that charges will be submitted to my health insurance in accordance with the provisions of my policy.

I assign payments to this office from my insurer for services to me or my dependents.

I understand that I am responsible for any non-covered services rendered to me or my dependents. I understand that the fee for services is $ 80 — per hour and that fees for consultations or collateral contacts that are face-to-face, by telephone or in writing, will be assessed by the 15-minute unit.

I understand that if I must cancel a scheduled appointment, 24-hour notice is necessary to avoid charges.

Confidentiality of records or information collected will be held or released in accordance with state laws regarding confidentiality of such records and information. I understand that state and local laws require that my clinician report all cases of abuse or neglect of minors or the elderly and that state and local laws require that my therapist report all cases in which there exists a danger to self or others. I understand that in some legal proceedings, upon a court order, testimony and/or records may be rendered. I understand that if legal actions are brought against my clinician by the patient and/or family, information may be disclosed if neces-sary and relevant to the case. I understand that there may be other circumstances in which the law requires a clinician to disclose confidential information.

I hereby authorize disclosure by Associates in Behavioral Health, LLC of any and all records regarding ____ ____________________ to my health insurance representatives if such disclosure is necessary for claims processing, case management, coordination of treatment, or utilization review purposes.

I hereby authorize Associates in Behavioral Health, LLC and ____________________ to exchange information for the purpose of coordinating my treatment.

I hereby authorize Associates in Behavioral Health, LLC to leave at my home telephone messages regarding appointments.

I hereby authorize Associates in Behavioral Health, LLC to leave at my place of work telephone messages regarding appointments.

I understand that I may revoke my consent at any time except to the extent that services have already been rendered or that action has been taken in reliance on this consent and that if I do not revoke this consent it will expire automatically one year after all claims for treatment have been paid as provided in the benefit plan.

I have read and understand the above.

____________________ ____________________
Signature Date

____________________ ____________________
Witness Date