Jay H. Berk, Ph.D., Inc.__________________________________

23293 Commerce Park, Beachwood, OH 44122
(216) 292-7170   FAX (216) 292-7182

Date: ____________________

Re: ____

This note is to confirm your appointment on ______________________,
_______________________,
at ______________ with me for an initial visit.

I am enclosing two packets. One is client information and background information to be completed for __________________. Please bring this with you to the appointment. The other packet is the Client Information/Office Policy Handout. Please read and sign and complete the attached Consent to Treatment Form and again bring with you to the appointment. Should you have any questions about the office policies, I will be happy to discuss them with you at the appointment.

There are several documents in the paperwork that require a witness signature. Please have an adult (spouse, relative, neighbor, co-worker, etc.) sign these pages before the office visit. Also, if you are bringing any school evaluations, IEP's, 504 Plans, doctor evaluations or reports, etc., please do not bring the originals. Bring a copy that I can keep for my reference. Your assistance with these items will make our visit be more focused on helping your child.

YOUR CHILD AND AT LEAST ONE PARENT MUST ATTEND THIS APPOINTMENT.

Also, please be sure that you have contacted your insurance company, if preauthorization is required, before the appointment.

I look forward to meeting with your family.

Sincerely,

Jay H. Berk, Ph.D.
Clinical Psychologist

Jay H. Berk, Ph.D., Inc.
Directions to Office

Address 23293 Commerce Park, Beachwood, OH 44122
Phone 216-292-7170

The office can be reached from South Green Road or Chagrin Blvd. If you will be traveling I-271 to reach the office, you can use either the Chagrin Blvd exit or the Harvard Road exit. The building is a one story brick building with the Leukemia Society and The Gathering Place as other tenants. Our office is located at the northern end of the building. The entrance door opens directly into the suite.

From Chagrin Blvd. –
* Commerce Park is located west of Richmond Road and I-271.
* Going west on Chagrin Blvd. turn left onto Commerce Park. There is a traffic light at the intersection. At the corners of that intersection, there will be a Beachwood Fire Department, a Huntington Bank, and a Key Bank.
* Once on Commerce Park, bear to the right where the road splits.
* Once you have rounded the curve, the office will be on the right.

From South Green Road –
* Turn right on to Mercantile Road. There is a traffic light at the intersection and the Beachwood Post Office on one corner.
* Approximately 500 feet, Commerce Park bears to the left.
* Our office will be on the left.

Please note that due to the traffic congestion at the Chagrin Blvd exit at 271, the Harvard Road exit may be a better exit to use.

Getting to the Office from the:

NORTH **Take I-271** South to the Chagrin Blvd. exit. Make a right turn from the exit ramp. Stay on Chagrin Blvd. until you reach Commerce Park.

SOUTH **Take I-271** North to the Chagrin Blvd. exit. Make a left turn from the exit ramp. Stay on Chagrin Blvd. You can also exit at Harvard Road and turn left. Take Harvard to South Green Road and turn right.

EAST **From 422**. Take 422 West to I-271North. Take I-271 North to the Chagrin Blvd. exit. Make a left turn from the exit ramp. Stay on Chagrin Blvd. until you reach Commerce Park. You can also exit at Harvard Road and turn left. Take Harvard to South Green Road and turn right.

From I-90. Take I-90 West to the I-271 South Split (bear to the left and it is best to stay in the Local Lanes.) Take I-271 South to the Chagrin Blvd. exit. Make a right turn from the exit ramp. Stay on Chagrin Blvd. until you reach Commerce Park.

WEST **From I-90**. Take I-90 East to the I-271 South Split. Take I-271 South to the Chagrin Blvd. exit. Make a right turn from the exit ramp. Stay on Chagrin Blvd. until you reach Commerce Park.

From 480. Take 480 East. When you are approaching the 480/422 split, follow the I-271 North signs, making sure you get into the LOCAL LANES for Harvard Road/Chagrin Blvd. DO NOT GET INTO THE EXPRESS LANES ON THE FAR LEFT as there is no exit before Chagrin Blvd. Take I-271 North to the Chagrin Blvd. exit. Make a left turn from the exit ramp. Stay on Chagrin Blvd. until you reach Commerce Park. You can also exit at Harvard Road and turn left. Take Harvard to South Green Road and turn right.

From I-77 North or South Follow the signs to 480 East. When you are approaching the 480/422 split, follow the I-271 North signs, making sure you get into the LOCAL LANES for Harvard Road/Chagrin Blvd. DO NOT GET INTO THE EXPRESS LANES ON THE FAR LEFT as there is no exit before Chagrin Blvd. Take I-271 North to the Chagrin Blvd. exit. Make a left turn from the exit ramp. Stay on Chagrin Blvd. until you reach Commerce Park. You can also exit at Harvard Road and turn left. Take Harvard to South Green Road and turn right.

CLIENT INFORMATION

Today's Date: ______________________________

Client Name: ____ Date of Birth: __________________
(Person to be seen) Last First Sex: M_____ F _____

Address: ____
Street Address City State Zip

Social Security #: _____________________ Referred By: ___________________________________

Marital Status: _______________________ Employment Status:____________________________

Home Phone: ________________ Work Phone: ________________ Cell Phone: _________________

BILLING INFORMATION

Responsible Party*: ____ Relationship: ______________

Home Phone: ________________ Work Phone: ________________ Cell Phone: _________________

Address: ____
(If different from client) Street Address City State Zip

I chose to self-pay for services rendered by Jay H. Berk, Ph.D. Inc. _____________
***If responsible party listed above is not the client, custodial parent, or parent responsible for payment for a child's mental health services, we must have written consent by that party in order to bill them. The person signing this document will be billed and held responsible for all charges until such written notification is received. By signing this form, I verify that I will be responsible for all fees incurred and that this document supercedes all other legal payment agreements. I understand that it is my responsibility to obtain such signatures at the time of services being rendered.**

INSURANCE INFORMATION

Insurance Company: ____ Phone: __________________

Claims Mailing Address: ____
Street Address City State Zip

ID#: _____________________________ Group#: _______________ Employer: __________________

Relationship to Subscriber: ____

Policy Holder Name: ____

Is preauthorization required? __________ Phone # for Authorization: ________________________

Authorization #: ______________________________ # of Sessions Authorized: _______________

Start Date: _________________ End Date: _________________ Copayment: $_____________

PLEASE NOTE: OUR OFFICE DOES NOT FILE SECONDARY INSURANCE
****You are responsible for providing accurate insurance information. Failure to do so will result in your being fully responsible for all charges. We must be immediately notified of any insurance changes. We cannot retroactively bill your insurance.**

<u>Professional Services Agreement with Jay H. Berk, Ph.D., Inc.</u>

Provider: Jay Berk, Ph.D.

I understand that the effectiveness of psychological procedures depends on efforts of the patient as well as those of the practitioner and I promise to make my best effort to comply with those procedures. These best efforts will include open and honest discussion of my thoughts and feelings, as well as an effort to perform any exercises or homework assignments that may be recommended. I also agree to return, undamaged, any materials that may be loaned to me as part of the procedure and understand that I am liable for the cost of those materials. I understand that the effectiveness of all procedures cannot be guaranteed.

I understand that regular attendance will produce the maximum benefits, but that I am free to discontinue treatment at any time. If I decide to do so, I will notify Dr. Berk at least two weeks in advance so that effective planning for continued care can be implemented. I also agree to notify Dr. Berk at least 24 hours in advance if I will be unable to attend any session. I understand that if I fail to make such notification, I may be charged for the full cost of the session which will not be reimbursed by my insurance company. I agree to be responsible for these charges.

I understand that conversations with Dr. Berk will almost always be confidential. I further understand that a mental health professional, by law, must report actual or suspected child or elder abuse to the appropriate authorities. In addition, Dr. Berk had a legal responsibility to protect anyone the patient may threaten with violence, harmful, or dangerous actions (including those to themselves), and may break the confidentially of our communications if such a situation arises

I request that Jay Berk, Ph.D., Inc., submit bills to the insurance company which I have listed on the reverse side of this form, and I grant permission to Jay Berk, Ph.D., Inc., to release such confidential information as is necessary to obtain payment from the insurance company. In the event that my insurance company fails to observe Ohio prompt pay standards or otherwise fails to adhere to appropriate business standards, I grant permission to Jay Berk, Ph.D., Inc. to share information related to my insurance claim with the Ohio Department of Insurance.

I understand that I am financially responsible for the cost of the psychological services to me or my child (if a minor) and for any portion of the fees not reimbursed or covered by my health insurance and if I elect to self pay. I also understand I am responsible for payment by signing this form and that if payment is to be made by any other party, they must sign a payment agreement or this document supercedes any other legal agreement for payment. If my mental health care is provided under the terms and conditions of a managed mental health care program to which Dr. Berk is contracted, my financial responsibilities may be limited by terms of that contract and I understand that I must comply to the rules of that insurance company such as, but not limited to gaining pre-authorizations and immediately notifying Jay Berk, Ph.D., Inc., of any insurance changes.

I understand that my failure to pay these bills may result in collection procedures (including court proceedings) being taken against me by Jay Berk, Ph.D., Inc., and by a collection agency contracted by Jay Berk Ph.D., Inc., to collect these bills. I also understand that I will be responsible for any additional charges incurred through the use of a collection agency or the filing of a court action including attorney and filing costs.

I understand that professional services will be rendered to me by **Jay H. Berk, Ph.D.**, and that the fee for a 45-50 minute initial session will be **$125.00**. Fees for ongoing therapy will be **$125.00** for individual/family therapy per session and **$50.00** for each group therapy session. There may be additional fees for psychological testing, legal consultation/testimony, and or other consultation. school meetings, if requested, will be billed at **$150.00** per hour plus travel time and are not insurance reimbursable.

May we contact the person who referred you to this office? Yes/No ____
Name and Phone Number

May we contact your physician? Yes/No____
Physician Name

____
Physician Address and Phone Number

My signature below indicates that I have agreed to the above terms and have received a pamphlet describing my rights and responsibilities as a patient or guardian.

_____________________________ Date: ________ _____________________________ Date: ________
Signature of Patient or Parent/Guardian Signature of Jay. H. Berk, Ph.D.

CHILD CLIENT INFORMATION

Child's Name: _________________________________ Age:________ DOB: ____________

Child's Address: ____

City: _______________________________________ State: _________ ZIP:_____________

Child's Telephone: ____

Child's School: ____ Grade: __________

Mother's Name ____ DOB: ___________

Mother's Address (If Different): ____

City: _______________________________________ State: _________ ZIP: _____________

Mother's Telephone: Home ______________ Work ______________ Cell ______________

Mother's Employer: ____ SS#: _____________

Mother's Health Insurance Co: ____

Authorization Necessary: Yes/No Telephone Number: _________________________

Father's Name: ____ DOB: ____________

Father's Address (If Different): ____

City: ____ State: ________ ZIP: _____________

Father's Telephone: Home ______________ Work ______________ Cell _______________

Father's Employer: ____ SS#: _______________

Father's Health Insurance Co: ____

Authorization Necessary: Yes/No Telephone Number: _________________________

With which parent does the child reside: ____

Referral Source: ____ Date: ________________

Jay H. Berk, Ph.D., Inc.___________________________________

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BACKGROUND INFORMATION FOR TREATMENT

Date: ______________________________

Name of Child: ____
Please Print

Age of Child: ________________________

Past Therapist(s):

Current Therapist(s):

Past Goals in Therapy:

Progress in Therapy:

Medication(s) – Current:

Name	Dosage	Doctor Prescribing	Results

Name: ____________________________________

Past Medication(s):

Current Diagnosis by Clinician (if known):

Past Diagnosis by Clinician (if known):

IEP at School: Yes No

For What:

What Recommendations:

504 Plan at School: Yes No

For What:

What Recommendations:

Medical Conditions:

General Comments:

SOCIAL SKILLS GROUP INFORMATION

Child's Name: ____
Please Print

Child's Age: ____

Person Completing Form: ____

Relationship to Child: ____

Main problem areas of the child with peer or self-esteem:

1)

2)

3)

What have you done to try and assist your child?

What do they do try to assist themselves?

What have they not successful at changes? (What goes wrong?)

Additional General Comments:

Jay H. Berk, Ph.D., Inc.

23293 Commerce Park, Beachwood, OH 44122
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Fees for Ancillary Services

By signing this agreement, I understand and acknowledge that Jay H. Berk, Ph.D., will charge for ancillary services which I may request. Such ancillary services may include, but are not limited to, phone calls in my or my child's behalf; consultations with schools and or staff; other physicians; other psychologists; correspondences; legal reports; review of records, etc. The services are not billed to insurance and thus I will be financially responsible.

Fee Structure:

School and/or Other Onsite Meetings: A fee of $150.00 per hour will be billed for a meeting where Dr. Berk is asked to attend an onsite consultation, including but not limited to school meetings. A $70.00 per hour travel time fee will also be billed and pro-rated according to actual driving time.

Fees for Telephone Calls to Physicians, Psychologists, Other Professionals, Record Review, Correspondences, Legal Reports, etc: A fee of $125.00 per hour will be billed when one of the listed services is requested of Dr. Berk.

I understand that Dr. Berk will bill these amounts only on the time that it takes him to perform the requested service. Thus, the hourly rate will be pro-rated based on the time taken for any or all of these services.

Services will not be provided unless requested and approved by the Client/or if a minor, the Parent/Guardian.

____
Client's Name (Please Print)

____
Signature of Client/Parent/ Guardian

____
Witness

____
Date

Jay H. Berk, Ph.D., Inc.________________________________

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CONSENT FOR TREATMENT OF A MINOR

I, ____,
(Parent or Legal Guardian's Name)

bearing the relationship of ____
(Parent, Legal Guardian, Grandparent, etc.)

to ____, do hereby grant permission to
(Minor's Name)

Jay H. Berk, Ph.D., to render the service or treatment necessary to the above mentioned patient.. This service to treatment is made to include care essential for the patient's condition.

Signed: ____

Address: ____

____

Relation to Patient: ____

Date: ____

Witness to Signature: ____

Jay H. Berk, Ph.D., Inc._______________________________________
23293 Commerce Park, Beachwood, OH 44122
(216) 292-7170 FAX (216) 292-7182

CONSENT TO TREATMENT AND FEE AGREEMENT

Jay H. Berk, Ph.D., Inc.

CONSENT

I have read the Service Agreement and have received a copy for my records. I hereby consent to enter into therapy with **Jay H. Berk, Ph.D.**

FEE

The fee for an initial consultation will be **$125.00**. After that, my fee will be **$125.00** per 45-50 minutes individual/family session and **$50.00** per group session, unless specified differently below. Although health insurance may aid in payment, I will be held responsible for paying for psychological services and appointments with my therapist. **Insurance companies do not pay for canceled appointments. If I cancel or do not keep an appointment without giving twenty-four hours' advance notice, I must pay for the time I have reserved.** There will be a $35.00 charge for any NSF check.

If I utilize health insurance to aid in payment, my signature below hereby grants authorization to Jay H. Berk, Ph.D. Inc., to release any Protected Health Information to my insurance company that is necessary for billing, or to process my claim for payment of services. My signature below authorizes my insurance company to send payment directly to Jay H. Berk, Ph.D., Inc., for all services provided. My signature below also authorizes my therapist to release claims forms (containing Protected Health Information) and supporting documentation to the Ohio Department of Insurance if Dr. Berk files a claim against my insurance company under the Ohio Prompt Payment Law. I agree that a photocopy of this authorization shall be valid as the original.

If my insurance company has contracted with Dr. Berk to accept a lower fee, my deductible and any non-insured portion of each session's fee will be based on that contracted amount. If the insurance company decides to increase the fee that Dr. Berk is allowed to charge, my deductible and any non-insured portion of each session's fee will be based on the increased amount. Sometimes managed care companies will authorize more sessions than my insurance benefits will pay for. If I see Jay H. Berk, Ph.D., for visits *that are authorized* but not paid for by my insurance benefits, by signing this form I am agreeing to pay Dr. Berk's fee, as listed above, for each authorized visit that is not covered by insurance benefits. Any monies received by Dr. Berk from my insurance company over and above my indebtedness will be refunded to me when my bill is paid in full or to the insurance company if they entitled to such funds.

If my insurance company requires me to get an insurance authorization before seeing Jay H. Berk, Ph.D. and I do not do so, I am responsible for payment in full of the fees listed above. Denied insurance claims become my responsibility for payment.

Occasionally, Dr. Berk may increase his standard fee. I will be notified in advance when an increase is about to occur. At that time, my fee will be adjusted to the new rate and the current fee agreement will be terminated. I will then be asked to sign a new fee agreement.

PAYMENT ARRANGEMENT

All accounts are payable in full within 30 days after billing. Overdue accounts may be charged interest at the rate of 10% per year.

_____STANDARD PAYMENT ARRANGEMENT: payment for any deductible or non-insured portion of my fee is due at each session.

_____ALTERNATIVE PAYMENT ARRANGEMENT: ____

____

COLLECTIONS PROCEDURE

Jay H. Berk, Ph.D., Inc., reserves the right to collect any unpaid balance due. If I am not making regular monthly payments on the account balance, Jay H. Berk, Ph.D., Inc., may use a collection agency or take legal action to secure payment, as authorized by state or federal law, and the collections actions will become part of my credit record. I will be notified in writing before Jay H. Berk, Ph.D., Inc, takes action to collect.

LIMIT ON UNPAID BALANCE

Dr. Berk may terminate treatment and refer me elsewhere for continued care if my unpaid balance exceeds $300.00

I have read and understood the above Consent to Treatment and Fee Agreement, and I agree to abide by its terms.

____
Client Name – Please Print

______________________________________ ____________________
Client/Parent and or Guardian Signature Date

Jay H. Berk, Ph.D., Inc.

23293 Commerce Park, Beachwood, OH 44122
(216) 292-7170   FAX (216) 292-7182

CLIENT INFORMATION AND CONSENT TO TREATMENT

Jay H. Berk, Ph.D., Inc., welcomes you and /or your family member to his professional services. Our priority is to make sure your experience is positive and successful. Success will also depend on your own efforts. You are encouraged and expected to take an active role from start to finish in you treatment, assisting in identifying what you and/or your family member need to focus on in treatment and developing a practical and effective course of action. Your active participation in treatment will allow our work together to be as focused and brief as your situation requires.

The following information is offered to familiarize you with the operation of our practice. Please feel free to ask for clarification if you have any questions about any of the information in this handout. A copy of this information/handout is available for you to take home for further reference. Thank you for choosing our office. We look forward to working with you.

QUALITY OF CARE AND OFFICE COMMUNICATION

Quality of Care/Client Satisfaction

Because Jay Berk, Ph.D., Inc., is committed to quality care, we may ask brief checklists describing you and/or your family member's progress in treatment and your satisfaction with services. Your responses will be used to evaluate and improve our services and will be kept anonymous and confidential. We appreciate your cooperation and input.

Support Staff

The support staff is available in the office at (216) 292-7170 on Monday, Thursday, and Friday from 9:00 am until 4:30 pm.
The office staff will be happy to help you with any questions you may have. When they are not in the office, your call will activate our confidential voice mail system. To use the voice mail with a touch-tome phone, press "4" to leave a message for Dr. Berk or press "5" for support staff. If you have a rotary phone, wait on the line for operator assistance.

Emergencies

In case of an emergency Dr. Berk or a colleague covering his calls can be reached at all times. Please phone the office and indicate the urgent nature of your call and request that Dr. Berk respond as quickly as possible. Every attempt will be made to respond in an expedient manner. If you are calling and reach the voice mail system, press "0" for operator assistance. If it is an extreme emergency, please call 911 or go to the nearest emergency room.

How to Handle Cancellations/ Appointments Changes

If it is necessary to cancel/change an appointment, please call as soon as possible so your appointment time can be made available for another client. MISSED APPOINTMENTS NOT CANCELED 24 HOURS IN ADVANCE WILL BE BILLED TO YOU AT THE USUAL FEE. Charges for missed appointments and late cancellations cannot be billed to insurance.

FEES, PAYMENTS, AND INSURANCE

Fees

Jay Berk, Ph.D., Inc.'s usual fee for service is $125.00 per hour (45 minutes of therapy plus 10 minutes of paperwork time) for an initial evaluation or individual and/or family therapy, $50.00 for group therapy (1 hour session), and $150.00 per hour for school consultation plus drive time. The following services will be billed at this usual hourly rate, according to the amount of professional time expended:

- Psychotherapy and counseling sessions;
- Psychological testing, including administration, scoring, interpretation, and report preparation;
- Consultation with outside professionals;
- Telephone conversations of more than 15 minutes;
- Court testimony, including travel time and waiting due to court delays. This will be billed at a different rate;
- Home visits, including travel time before and after sessions.
- School Consultations, Drive time to and from the meeting.

Other expenses in support of services (i.e., long distance phone calls, travel expenses, etc.) may be billed separately.

Payments

PAYMENT FOR SERVICES ARE DUE AT THE TIME SERVICES ARE RENDERED, AND YOU, THE CLIENT ARE RESPONSIBLE FOR PAYMENT OF THE FULL PROFESSIONAL FEE unless other payment arrangements have been approved in advance with our office or are a part of your insurance company's agreement with Jay H. Berk, Ph.D.

It is the policy of this office that the parent/guardian (custodial or non-custodial) accompanying a minor client for treatment will be held accountable for all bills. Children and minor clients can only be seen with the written permission of a custodial parent. If you are not the custodial parent, please notify us. If the parent not accompanying the child is to be billed, you must obtain their signature on the form that states responsibility for payment or you will be responsible for payments.

Insurance and Managed Care

We make every effort to maintain and extend membership on a range of insurance and managed care provider panels. Please keep in mind that health insurance coverage for outpatient mental health services varies with different policies, insurance companies, and managed care organizations. Also remember that contracts vary on covered services, providers, and reimbursement amounts.

Before treatment begins, it is <u>your responsibility</u> to inform our office of any <u>insurance coverage</u> you have to help cover the cost of your treatment. You will need to obtain <u>copies of your insurance forms</u> from your insurance company or employer, and you will need to know the <u>percentage of co-payment</u> for which you will be responsible for paying at each visit. You will also need to know if there is a deductible on the mental health portion of your policy and whether you have met your mental health deductible. Payment of the full agreed-upon fee is expected at each visit until your deductible is met. After treatment is underway, it is your responsibility to inform our office if your insurance coverage changes in a timely fashion so that the original payment arrangements can be revised if necessary.

You will need to obtain any pre-certification/authorization required by your managed care insurance company before your first session.

Submitting insurance forms to the insurance company will be done by the office staff.. We do not submit secondary insurance.

Accounting Balances

A monthly statement will be sent only if you owe a balance on your account. The statement will show services rendered, client payments made, and insurance payments made. Any monies received by Jay Berk, Ph.D., Inc., from insurance companies or managed care organizations over and above your indebtedness will be refunded to you when your bill is paid in full. A $25.00 charge will be made for any check returned for non-sufficient funds (NSF). We realize that periodically financial problems arise that my effect your ability to pay your account balance. If such problems arise, please contact our office promptly for assistance in the management of your account. Accounts with outstanding balances which have gone unpaid for 90 days will be considered for collections.

RELEASE OF INFORMATION AND CONFIDENTIALITY

General

Information shared with Jay Berk, Ph.D., Inc., is privileged and confidential. This information cannot be shared with anyone without your written permission (exceptions noted on page 4 of this document). Only your signed release of information authorizes Jay H. Berk, Ph.D., Inc., to acknowledge that Dr. Berk or his staff is working with you to anyone (lawyers, teachers, spouses, etc.). If you have received previous medical or psychological treatment, Dr. Berk or his staff may ask you to sign a specific release form which will allow your previous physician/counselors to discuss your prior treatment. If it is necessary for Dr. Berk or his staff to consult with a colleague about your treatment, your identity is protected and kept anonymous.

Insurance and Managed Care

When you sign your insurance form, you are authorizing Jay Berk, Ph.D., Inc., to furnish your diagnosis types of services rendered, dates of service, charges, and referring physician information to the insurance company. If a particular insurance company requires more information about you from Dr. Berk or his staff, it will be provided to your insurance company unless you tell us not to do so. Managed care organizations frequently require brief verbal or written treatment update information before additional services can be authorized medical necessary. By signing this form, you authorize Dr. Berk to complete treatment plans for your insurance company (if required), if you have elected to utilize your insurance for payment of claims.

Children and Adolescents

When the client is a minor, the parent or guardian will be asked to sign a statement permitting evaluation and treatment. Although it is therapeutically important that the specific thoughts and feelings of minors remain confidential, parents and guardians will be periodically informed of the general process and progress of treatment. Minors will be informed of all consultations with parents/guardians and outside professionals. Parents and guardians will also be involved in the treatment process through family sessions and/or parent guidance.

Exceptions to Confidentiality

The only occasions in which Jay Berk, Ph.D., Inc., would be obligated by law to break confidentiality would be:

1. If the client is deemed to be harmful to herself/himself or to someone else;
2. If there is a reason to suspect child abuse (the client could be the alleged victim and/or perpetrator); or,
3. If specific information and/or client record is subpoenaed by a court of law.

Treatment Non-Compliance

I understand that treatment recommendations will be made to assist myself and/or my child. I further understand if Dr. Berk deems the situation as one where critical treatment recommendations are not being followed, treatment may be discontinued and I will be offered other therapists. I also understand that if critical information is not disclosed, treatment may also be discontinued since best practices cannot observed.

Jay H. Berk, Ph.D., Inc.______________________________________

23293 Commerce Park, Beachwood, OH 44122
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Client Name: ____-

I fully understand that the parent that signs this Client Information and Consent to Treatment Form is responsible for payment. If another parent is to be billed and is responsible, their signature must be provided to Dr. Berk on the proper forms. If the signature of the additional parent it is not obtained, then the parent/guardian signing this form is solely responsible for payment. This agreement is understood to override any other legal arrangements or court agreements. If any changes are to be made to this agreement at a later date, they must be presented to this office in writing and signed by all parties.

____
Parent/Guardian – Please Print Name

____ ____________________
Parent/Guardian Signature Date

____ ____________________
Witness Date