Ronald J. Refice, PhD & Associates, LTD
650 Boulevard Ave.
Dickson City, Pa. 18519
Phone: 570-383-2799 Fax: 570-383-0063

Welcome to Ronald J. Refice, Ph.D & Associates LTD. We are pleased that you have chosen us to meet your mental health needs. We anticipate that you will be pleased with the service provided to you. Your feedback is always welcome .

This practice is a group of clinicians who choose to join together in utilizing office space and other services. We all practice as individuals and are not responsible for the practice of our associates.

We have put together some information that you may find helpful. This guide offers information about fees, appointments, insurance, messages etc. Please read it and talk with us about any questions or concerns you may have.

APPOINTMENTS

Except for rare emergencies, your therapist will see you at the time scheduled with minimum waiting. An ordinary session lasts approximately 50 minutes. Because this time is set aside for you, it is important that you keep this appointment. It is understood that on occasion, circumstances may arise which require you to cancel. In these cases, please provide at least 24 hour notice.
Without 24 hour notice, you may be billed a cancellation/no show fee.

HEALTH CARE INSURANCE

Many insurance plans will cover a *percentage* of the cost of your treatment if the treatment is deemed to be medically necessary. The reimbursement and procedures vary significantly from plan to plan. **Many plans require pre-authorization before your first visit. Please be aware of whether you need preauthorization and be sure it has been obtained either by you or this office.** We will assist in any way that we can but it is ultimately your responsibility.
Copayments and coinsurance are required at the time of the sessions.
Should you have difficulty paying your portion, please discuss this with your therapist.

In regard to court ordered evaluations which include custody, these situations are not considered to be medically necessary and therefore insurance companies do not provide coverage for this type of service.

FEES FOR SERVICE

If you do not have insurance coverage for mental health services , we do offer a private pay plan. The fee for service provided varies depending on the type of service provided and the provider. Some adjustments may be made depending on your financial situation and information provided to us. You will be asked to complete a basic financial assessment. Should you have insurance coverage but find it difficult to meet your portion, once again, please discuss this with your therapist.

CONFIDENTIALITY

All information shared is strictly confidential. It will not be released in any form except with written permission. The only exceptions are indications of harm to self or others or in the case of reported child or elder abuse. Such conditions legally require appropriate action by therapist.

CONTACTING YOUR THERAPIST

We use an answering service to handle requests for appointments, cancellations, emergencies. If you have an emergency the service will attempt to reach your therapist however this is not always possible. An emergency is considered to be a life threatening situation. In this case, you should call 911 or go to your nearest Emergency Room.

Appropriate telephone contact with your therapist is to arrange or clarify appointment times or to request other specific information. Telephone calls will be limited to 5 to 10 minutes. Telephone calls which require a longer amount of time indicate the need for a face to face session.

ELECTRONIC COMMUNICATION

compromised in some Some therapists in this practice may utilize text messaging and email in communication with you. Please keep in mind that electronic communication cannot be considered to be completely confidential or foolproof. We are all aware of situations in which a person's email account or telephone have been fashion. Please

keep this in mind should you choose to have this type of communication with your therapist.

In addition, there are times when an email or text are not delivered promptly by a server or your therapist may not check their accounts regularly. If you intend to use electronic communication with your therapist, please discuss in advance how it will be used and what the limits are. Also, please be advised, that Refice and Associates are not liable for any problems related to electronic communication.

FEEDBACK

Therapy is a process which requires work on the part of the therapist and yourself. The course and success of your therapy is a joint responsibility between you. It is important that you provide feedback to your therapist regarding what is happening in your session. This is an important part of the therapeutic relationship and can insure a successful outcome.

TERMINATION

Termination of therapy should be mutually agreed upon within a scheduled session. The therapeutic relationship usually means a great deal to both therapist and client. In order to maximize the benefits of therapy, it is in your best interest to terminate in a planned session.

REFERRALS

Most of our referrals come from our current and former clients. This is the best compliment you can give to us on our professionalism and skills. Please feel free to refer friends or family if they are in need of our services.

CLIENT REGISTRATION FORM

First Session Date_____ Therapist _____Office _____

Name _____

If Child, Parent's Names_____Spouse's Name _____

Date of Birth _____ Age _____ Marital Status _____Home Phone _____
Leave message ? Yes____ No _____

Address _____City _____ Zip _____

Social Security Number _____Driver's License Number _____

Employer _____ Work Phone_____

Referred by _____ Relationship _____

Other number(s) where you can be reached _____
Do we have permission to reach you at the above numbers? **YES** **NO**
Please specify if there are any requests with regards to contacting you
(Ex. Do not leave messages, etc)
_____

MEDICAL INFORMATION

Personal Physician and Address _____

Date of Last Physical _____Current Medications _____

Major/Chronic Illnesses _____ Previous Psychotherapy? Yes/No

If Yes, Dates and Therapist _____

INSURANCE INFORMATION

Primary Insurance Company _____

Name of Insured_____Relationship _____

SS # of Insured _____Insured Date of Birth_____

Insurance Group Number _____ ID _____

Insurance Company's Billing Address
_____

Secondary Insurance Company_____

Name of Insured _____ Relationship _____ DOB _____

Insurance Company's Address

_____

Insurance Group Number _____ ID _____

SIGNATURE ON FILE: I authorize use of this form on all of my insurance submissions. I authorize release of information to my insurance companies for billing purposes. I authorize insurance payment directly to Dr. Ronald Refice & Associates, if applicable. I understand that I am ultimately responsible for my bill. I permit a copy of this authorization to be used in place of the original.

_____ _____ _____

Print Name Here **Signature** **Date**

Please list any special insurance billing information or instructions _____

_____

Emergency Contact _____ Relationship _____

Address and Phone_____

PLEASE GIVE YOUR INSURANCE CARD TO YOUR THERAPIST TO PHOTOCOPY AND BRING IN YOUR INSURANCE FORMS ON YOUR NEXT VISIT

Please do not complete below this line

FOR OFFICE USE ONLY

Preliminary Diagnosis:

Axis I _____ Code _____

Axis II _____ Code _____

Axis III _____ Code _____

Axis IV _____ Code _____

Axis V _____ Code _____

Fee _____ Adjustment? _____

Special Notes to Billing Office

_____

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CONSENT FOR TREATMENT FORM

This is to certify that I give permission to Ronald J. Refice, Ph.D & Associates to provide psychotherapy treatment for myself and/or my child(ren).

I will be treated with respect and honesty throughout treatment. I am expected to benefit from treatment, but there are no guarantees. Maximum benefits will occur with regular attendance, but I understand that I may temporarily feel worse while in treatment.

While under most circumstances, all communication between the client and the therapist is confidential, Pennsylvania State Law mandates the reporting of actual or suspected child or elder abuse to the appropriate agency.

It has also been upheld that if an individual intends to take harmful or dangerous action against another, it is the therapist's duty to warn the person or the family of the person who is likely to suffer the results of harmful behavior. Similar actions are taken with clients who may have had suicidal thoughts and desires.

Every reasonable effort will be made to appropriately resolve these issues or to notify the client before such a compromise of the client-therapist relationship is made.

I have the right to terminate the therapeutic relationship at any time that I should desire without fault. I understand that payment for services is my responsibility and for any balance not covered by my insurance carrier.

A copy of this authorization shall be considered valid.

_____ _____
Signature of Responsible Adult Date

_____ _____
Signature of Treating Therapist Date

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CONSENT TO USE AND DISCLOSE YOUR HEALTH INFORMATION

This form is an agreement between you, _____, and Dr. Ronald Refice & Associates. "You" will mean your child, relative, or other person, if you have written his/her name here _____.

When we evaluate, diagnose, treat, or refer you, we will be collecting what the law calls "Protected Health Information (PHI) about you. We need to use this information to decide on what treatment is best for you and to implement that treatment. We may also share this information with others who provide treatment to you or need it to arrange payment for your treatment by a third party payor (i.e., health insurance company, billing department, etc).

By signing this form, you are agreeing to let us use your information and send it to others. The Notice of Privacy Practices (NPP) posted in the office explains in more detail your rights and how your information is used and shared. Please read this before you sign this consent form.

If you do not sign this consent form agreeing to what is in our Notice of Privacy Practices we cannot treat you.

In the future how your information is used and shared may change and so may our Notice of Privacy Practices. If this occurs, you can get a copy by calling (570) 383-2799.

If you are concerned about some of your information, you have the right to ask us not to use or share some of your information for treatment, payment, or administrative purposes. You will have to give this information in writing. Although every effort will be made to respect your wishes, we are not required to agree to any limitation set forth by you. However, if your request is agreed to, compliance will occur.

After you sign this consent, you have the right to revoke it by writing a letter stating that you no longer consent to the use and disclosure of your information. We will comply with your wishes from that time on, but some information may have already been used or shared.

_____ _____
Signature of client or his/her parent/personal representative Date

_____ _____
Printed name of client or parent/personal representative Relationship to the client

Date of NPP _____ ☐ Copy given to the client/parent/personal representative

Ronald J. Refice PhD and Associates Financial Policy

Thank you for choosing our practice! We are committed to providing you with the best possible care for your needs. Understanding our financial policies is an important factor in your treatment and care.

Insurance Information Our office will file a claim with your insurance company promptly, provided that you provide us with all of the pertinent information regarding your insurance. Of course, insurance coverage varies widely, and we cannot always guarantee what services will or will not be covered by your particular plan. Whenever possible, your insurance company is contacted before your initial visit and this certainly assists you and this office in knowing up front what to expect in terms of coverage. However, on occasion, after a claim is submitted we learn that the coverage is not what had originally been quoted. Unfortunately this is beyond our control and you can be assured that you will be notified immediately of any changes. Should a company refuse payment, we will do everything that we can to assist you in appealing this. Ultimately, however, responsibility for the charges belong to the you.

Participating Insurances - We currently participate with BlueCross, Medicare, UBH, First Priority Life, First Priority Health, Cigna, Aetna, Geisinger, Tricare and many other commercial insurances and managed care networks. We are also willing to explore participation in any other network that we are not currently participating with in order to assist you in utilizing your Mental Health Benefits.

Referrals For the most part, referrals are not necessary for mental health treatment. Should you have a particular insurance plan which requires a referral, it is your responsibility to provide this at the time of your initial appointment.

Third Party Involvement There are situations in which third parties are involved in treatment particularly in child custody and other matters involving children. You may be billed should your situation require extensive letter writing, reports and other communication with third parties. Your therapist will discuss this with you prior to any additional fees being incurred.

Payment Information Payment for service is due at the time of your visit. This includes all copayments, coinsurance and private pay fees.

Fee for No Shows and Late Cancellations Unless there is an emergency you are requested to provide 24 hour notice of any cancelled appointments. You will be charged $50 should you fail to provide 24 hour notice or fail to keep your scheduled appointment.

Past due- Patients who have not made an effort to pay on their account will be expected to satisfy their financial obligations to us before returning for service.

Returned checks- A fee will be added to your account for any returned checks that we receive.

Minor patients- The legal parent or guardian accompanying the child is responsible for payment.

Our billing department is available to answer questions and discuss your concerns. Call 570-383-2799.

I have read and understand the financial policy as outlined above and agree to adhere to its terms.

_____ _____

Patient or Responsible Party's Signature Date