TERRAP ANXIETY AND PHOBIA CARE
COGNITIVE AND BEHAVIORAL HEALTH ASSOCIATES

A division of Julian M. Herskowitz, Ph.D, Psychologist, P.C.
755 Park Avenue * Suite 140 * Huntington, N.Y. 11743
Tel: 631.549.8867 **Fax: 631.423.8446**

OFFICE POLICY

******REFERRAL SOURCE**: _____ (this must be filled out)****

Patient name: _____ Date of birth: _____

Insured's name: _____ Date of birth: _____

Insured's address: _____ S.S #: _____

_____

Home #: ( )_____ Work #: ( )_____ Cell #: ( )_____

Employer Name and Address: _____

_____

Insurance: _____ Insurance ID #: _____

PLEASE READ THE FOLLOWING AGREEMENT CAREFULLY

1. All cancellations (no matter what the reason) must be made 24 hours in advance, otherwise YOU will be charged the full session fee.
2. Sessions are scheduled for 45 minutes. If you come late to session, we are unable to just our schedule.
3. It is understood and agreed that the client should give feedback, both positive and negative, to the therapist to maximize treatment benefits. It is further agreed that if I wish to terminate treatment at any time, or even reduce frequency of visits, I will discuss it with the therapist.
4. I agree to follow the verbal treatment plan formulated by the therapist. If I do not follow the treatment plan, the therapist has the right to terminate treatment.
5. Payment or co-payment is expected at the time of the office visit. Bounced checks will require a $25.00 bounced check fee.
6. All bills or insurance forms will be mailed out every two to four weeks depending your insurance.

I hereby authorize, Terrap Psychological Associates of New York to furnish required information to insurance carriers concerning my diagnosis and treatment. I understand that I am responsible for any amount not covered by my insurance and agree to pay interest on any past un-paid balance and or collection/ attorney fee if account is assigned to be enforced. If we are accepting assignment for your insurance and the insurance company sends the payment to you, or the policyholder, you will be held responsible to reimburse TERRAP directly.

Agreed and understood,

_____ _____

Patient or legally authorized individual signature Date

_____ _____

Printed Name if signed on behalf of the patient Relationship (parent, legal guardian, personal representative, etc.)