

**Brain Healing Center**  
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## **POLICY INFORMATION and INFORMED CONSENT**

This information guide has been prepared to acquaint you with policies affecting issues that frequently arise over the course of treatment. **Please read this guide carefully as your signature on this document will indicate that you have read it, understood it, and agree to its provisions.**

### **CONFIDENTIALITY:**

Historically, complete confidentiality has applied to communications between state boards licensed clinicians and client. However, legal developments have occurred which require clarification with regard to confidentiality. Generally anything done or said in the context of Counseling, Biofeedback, Neurofeedback, is privileged, with these exceptions:

1. If a client behaves in a way that poses a threat of a physical nature to self or to another person, privilege is waived. The clinician is bound by law to contact the proper authorities, as well as any other person(s) involved, and warn them of possible danger.
2. If a client is using confidentiality as a means of avoiding legal punishment, privilege is waived. That is, clinicians may not aid or abet the perpetration of a crime.
3. Court-ordered disclosures of information related to treatment.
4. During a medical emergency.
5. Mental health providers are bound by law to inform authorities of past, ongoing, threatened, or suspected child abuse.
6. If you as the client or parent if the client is a minor, signs a release of information form.
7. Information may be requested to process your insurance claim and released to the insurance company.

With regard to minors, parents/guardians of minors hold the privilege and are entitled to information communicated by their children in counseling and EEG Biofeedback. However, ethical standards require communication of information related to services provided only in ways that will be helpful.

### **APPOINTMENTS:**

Treatment sessions are scheduled for 45 minutes long and are by appointment only. Brief and extended appointments can be arranged when necessary. If you find it necessary to cancel a scheduled appointment, **the cancellation must be made 24-hours in advance.** Appointments missed without 24-hour notice **will be billed at the full rate. After four such cancellations our relationship is subject to treatment termination.** Efforts will be made to alter schedules when occasional conflicts arise, but late cancellations or requests for changes become mutually disruptive.

### **FINANCIAL ARRANGEMENTS:**

The cost of billing and documentation that is imposed by insurance companies is very burdensome and costly. We are happy to file your insurance for you and provide the documentation, but the uncertainty of payment and frequent obstacles and requirements that carriers impose can be financially damaging. **It is for this reason that we ask that you pay for services as rendered.** The carrier can then reimburse you personally. ***If Dr. Gluck or***

***the Center is a panel member of your HMO or PPO and the service(s) billed for is a covered service and you are authorized to see Dr. Gluck or in the Center for the services provided, then the only payment due is the co-payment at the time of service.*** Dr. Gluck and the Center will always respect contractual obligations to your insurance carrier.

**Each treatment authorization we receive comes with a warning that authorization for treatment does NOT guarantee payment for the service.** As illogical as that appears, that is the current practice in the insurance industry. If we make a substantive error and that is the reason for non-payment, we do not hold you responsible. However, in all other cases, if the insurance company refuses payment you are still responsible for the payment for services.

**DIAGNOSIS:**

Clients whose costs are covered by insurance should be aware that coverage always requires a diagnosis, and for this reason, the diagnosis may be included on your invoices and case records. Questions you have regarding your insurance company's policies on confidentiality of their records should be taken up with the company directly.

**RELEASE OF INFORMATION:**

Counselors are often asked to send records to, or request records from, other health professionals, schools, agencies, and others. On these occasions you will be asked to sign a "Release of Information" form. No information will be released without your signed written consent in accordance with applicable law. Clients/parents/guardians have the right to access, upon request, their own/their child's records, in accordance with applicable law. Your/your child's records will be maintained for up to three years and can be reviewed with you upon your request.

**MEDICATION:**

All decisions regarding medications must be handled by the clients' physician and/or psychiatrist.

**Series Purchase:** If I purchase a series of sessions (at a discounted rate) paid for in advance and must cancel the remainder of the series I understand that my refund will be based upon the NON-DISCOUNTED rate.

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**I HAVE READ THE FOREGOING "Informed Consent for Treatment", understand it, and have clarified all uncertainties before signing. I understand that there are usually significant improvements but that some people do not improve, become worse before they become better, or may even, in very rare cases, find their problems have worsened. I hereby release Dr. Gerald Gluck, Ph.D., LMFT, PA and the (DBA) Center for Family Counseling and Biofeedback, The Brain Healing Center and any treating clinician I and/or my child/children treat with and/or his/her sources of supervision, from any liability related to my/my child's treatment and agree to hold him/her, and/or his/her sources of supervision, harmless from any effects caused directly or indirectly from Counseling/or EEG Biofeedback. My signature below serves as my consent for Gerald Gluck, Ph.D., LMFT, PA and Brain Healing Center and any treating clinician or intern within the Center and the Center for Family Counseling and Biofeedback to provide Counseling and/or EEG Biofeedback or a Quantitative EEG. I further agree that my therapist may discuss my case with his or her supervisor.**

Name of Client: \_\_\_\_\_ Signature of Client: \_\_\_\_\_

\_\_\_\_\_  
(Printed name of witness) (Signature of witness) Date: \_\_\_\_\_