



**---NOTE: YOUR SIGNATURE REQUIRED BELOW---**

Briefly state the problems for which you are seeking care:

Are you currently under another professional's care for psychotherapy? \_\_\_\_\_ Counseling in the past?

If yes, when and with whom?

Referral Source: \_\_\_\_\_ Do we have permission to send a thank you letter? \_\_\_Y \_\_\_N

**CANCELLATION POLICY**

Your appointment time is reserved each week especially for you and your therapist will make every effort to avoid disruptions in scheduling, and in unavoidable cases such as illness, offer to reschedule. Adherence to the schedule established by you and your therapist is, therefore, a goal shared by client and clinician in order to optimize your treatment. Since it is typically not possible for your therapist to fill a session cancelled less than 48 hours in advance, a missed session or late cancellation will be charged to you though it was not attended. Please note that insurance companies do *not* pay for missed sessions and you will be responsible for the full amount. In case of serious unavoidable circumstances, your therapist will use his or her discretion regarding charges. It is our experience that most sessions are regularly attended and that charges for cancellations are rarely required.

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**ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION**

I authorize payment of medical benefits to Cognitive Dynamic Therapy Associates, Inc. or any of its representatives on my behalf for services furnished to me by any member of their group practice. I authorize any holder of medical information about me to release any information needed to determine these benefits payable for related services. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by an insurance carrier. By signing below, I hereby authorize said assignee to release any information necessary to secure payment.

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**CONSENT FOR TREATMENT**

I (or \_\_\_\_\_ acting on behalf of \_\_\_\_\_)  
Consent to psychological evaluation and treatment by the psychologists and employees of Cognitive Dynamic Therapy Associates. I have received and read the policies as outlined in the CDTA Office Policy Brochure. The guidelines as delineated are understood and accepted by me. I understand that I may discuss my treatment with my therapist and may withdraw my consent if I so desire. I further understand that no guarantees have been made to me about the outcome of this care.

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My signature indicates that I have reviewed and truthfully responded to the information requested on this form. I have read and understand the above cancellation policy, assignment of benefits and consent for treatment. I agree to adhere to them until further written notice.

**Patient/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Appendix E**  
**Release of Information for**  
**Communication with Primary Care Providers**

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**Authorization to Disclose Information**  
**To Primary Care Physician**

I understand that my records are protected under the applicable state law governing health care information that relates to mental health services and under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in state or federal regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. This release will automatically expire twelve months from the date signed.

I, \_\_\_\_\_, hereby authorize \_\_\_\_\_  
*(Please Print Patient's Name)* *(Please Print Treating Clinician's Name)*

Please check one:

- \_\_\_\_\_ To release any applicable information to my Primary Care Physician  
\_\_\_\_\_ To release medication information only to my Primary Care Physician  
\_\_\_\_\_ Not to release information to my Primary Care Physician

\_\_\_\_\_  
*(Patient's or Patient's Guardian, please sign)* *(Date)*

\_\_\_\_\_  
*(Please Print the Name Signed Above)* *(Date)*

**Primary Care Physician's Name, Address, and Phone:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Note to Behavioral Health Care Provider:**  
**Please maintain original copy in patient's file.**

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## FINANCIAL POLICY

I, \_\_\_\_\_, understand that I am financially responsible for any and all charges incurred in this office whether or not paid by my insurance carrier.

I hereby assign payments to be made to Cognitive Dynamic Therapy Associates or any of its representatives on my behalf for services provided to me by any member of the group practice.

\_\_\_ I do not have insurance at this time or it will not cover services in this office.

\_\_\_ I have insurance but elect not to use it for these services and will self-pay.

\_\_\_ My insurance carrier will cover \_\_\_\_\_ sessions and pay \_\_\_\_\_ per visit. I will be responsible for any remaining balances.

Insurance regulations mandate that all co-payments are due *at the time of service*. CDTA accepts cash, personal checks, Visa and MasterCard. Please give your co-payment to the therapist at each session.

I agree to the terms and agreements of this notice.

Signed: \_\_\_\_\_

Dated: \_\_\_\_\_

Witness: \_\_\_\_\_

