Palm Beach Pediatrics Mental Health Program

Our mental health program is a specialty program staffed by Palm Beach Pediatrics clinical therapists (LMHC/LCSW/LMFT). Services are provided to children, adolescents and their families for behavioral, emotional, social and school problems. Our goal is to provide collaborative care between physicians and therapists for comprehensive assessment and treatment for a wide range of behavioral and emotional concerns.

Appointment Information:

All patients are required to be established patients of Palm Beach Pediatrics and up to date on yearly physical exam. An initial mental health assessment typically takes 45-60 minutes. The child and at least one of his/her parent(s)/legal guardian must attend the first appointment. You may be asked to complete initial paperwork or online survey to gather the child's and family's history as well as the presenting concerns. We ask you to complete surveys thoroughly and honestly to prepare for initial visit.

After an initial consultation, additional therapy appointments may be scheduled. Therapy appointments typically last 45-60 minutes. Appointment times before and after school are available; however, these appointment times fill rather quickly. Please contact the office to schedule appointments with a care coordinator.

Consent for Therapy

We hope parents understand that children with two parents have the best chance to benefit from therapy if both parents are involved and cooperate with each other and the therapist. While parents can expect benefits from this treatment for the child, they fully understand that a particular outcome cannot be guaranteed. The parents understand they are free to discontinue treatment of the child at any time, while recommended to discuss any plans to end therapy with therapist before doing so. Any patient who does not participate in therapy services for more than 90 days will be required to complete a screening prior to scheduling a follow up session to re-evaluate concerns and presenting problems.

We ask parents to understand that therapy can sometimes cause upsetting feelings to emerge, and that the child's problems may worsen temporarily before improving.

In the event of a divorced household, both parents are required to follow divorce agreements for consent of medical and/or therapy services.

Cancellation Policy

A cancellation policy of 24 hours prior to your scheduled appointment is required. If fewer than 24 hours notice is provided prior for an initial assessment, your child will be placed on a waiting list for a new assessment appointment. There will be a $50 fee for any missed appointment or any appointment cancelled less than 24 hours prior to the scheduled appointment time. This fee is considered non-billable by insurance companies and you will be responsible for the charge. Late cancellations on 2 or more occasions will require us to discuss alternative plans for your child's mental health needs.

Insurance Information

While most insurance companies reimburse for mental health services, coverage for mental services is determined by your individual policy. Palm Beach Pediatrics Mental Health Program is considered an out-of-network provider by all commercial insurance plans. We are required to collect payment at the time of the appointment, which you should be notified of by our billing team prior to appointment.

The patient (or the patient's parent, legal guardian, or authorized representative) retains responsibility for full payment of all fees, whether or not they are covered by insurance. For more detailed information about fees and insurance, please review policies or contact our Billing Department (561-327-4951).

Please contact your insurance provider to find out if your policy includes coverage for therapy offered by out-of-network providers for mental/behavioral health. If your policy does include coverage, your insurance representative should be able to explain the details of your coverage and the procedures for filing for reimbursement. You can request a receipt including details of the therapy services to submit.

Confidentiality

The parents, as legal guardians of the child, have rights to general information about what takes place in child's therapy, progress in therapy, and any dangers the child might present to self or others. The parents understand that confidentiality is important for the trusting relationship between the child and the clinical therapist, especially for children over the age of 12. If the parents would like more extensive support or consultation regarding child's progress, it is required to schedule an individual appointment or phone session with therapist to review at length (fees apply).

The parents have received a HIPAA notice of Privacy Practices from Palm Beach Pediatrics as established patients. The parents understand that information about psychotherapy is almost always kept confidential by therapist and not revealed to others besides the parents unless a parent authorizes such a release. The following exceptions are as follows:

1. Requirement by law to report suspected child abuse or neglect to proper authorities.
2. If child tells therapist that he or she intends to harm another person, the therapist must try to protect the endangered person, including by telling the police, the person and other health care providers. If a child threatens to harm him or herself, or a child's life or health is in any immediate danger, the therapist will try to protect the child, by telling the police and other health care providers who may be able to assist in protecting the child.
3. If a child is involved in certain court proceedings the therapist may be required by law to reveal information about the child's treatment. These situations include child custody disputes, cases where a patient's psychological condition is an issue, lawsuits or formal complaints against the therapist, civil commitment hearings and/or court-order treatment. Separate fees apply if therapist is required to participate in said situations.
4. If parents' and child's health insurance or managed care plan will be reimbursing, they may require confidentiality be waived to give information about child's treatment.
5. Collaboration with providers at Palm Beach Pediatrics may be necessary to provide comprehensive care.

Palm Beach Pediatrics Mental Health Program

Informed Consent to Therapy Services

By signing below the parents indicate they have read and understand this important information and agreement, that they give consent for child to participate in therapy services, and that they have the proper legal status to give consent to therapy for the child.

Printed Name of Child: _____

DOB: _____

Signature of Child: _____

(If over 12 years old)

Printed Name of Parent/Guardian: _____

Signature of Parent/Guardian:_____ Today's Date: _____

Printed Name of Parent/Guardian: _____

Signature of Parent/Guardian:_____ Today's Date: _____

Palm Beach Pediatrics Mental Health Program

Consent for Communication Form

I hereby authorize Palm Beach Pediatrics Mental Health Services to communicate regarding my child's health needs. This information is being used or disclosed to carry out treatment planning regarding Psychological/Psychiatric conditions, Drug/Alcohol information, IEP/504 planning and educational recommendations.

I understand I have the right to revoke this authorization, in writing, at any time by sending written notification to Palm Beach Pediatrics Mental Health Program. I understand a revocation is not effective to the extent that Palm Beach Pediatrics has relied on the use or disclosure of the PHI for my child.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

Palm Beach Pediatrics Mental Health Program will not condition my child's treatment, payment, enrollment in a health plan or eligibility for benefits whether I provide authorization for the requested use or disclosure.

Name of Contact:_____

Circle One: School/Guidance Counselor/ Therapist/Psychiatrist/Hospital/ Other:_____

Telephone Number: _____

Fax Number: _____

Child's Name: _____

Child's DOB: _____

Printed Name of Parent/Guardian: _____

Signature of Parent/Guardian:_____ Today's Date: _____