Boston Child Study Center

Expert Mental Health Treatment, Training & Research

BCSC

REGISTRATION PACKET CHECKLIST:

- ☐ **COMPLETE** Registration Information (pages 2-4)
- ☐ **READ & SIGN** Consent for Services (pages 5-8)
- ☐ **READ & COMPLETE** Online Progress Monitoring at BCSC (page 9)
- ☐ **COMPLETE & SIGN** Authorization for Exchange of Information (page 10)
- ☐ **COMPLETE & SIGN** Audio/Video Recording Consent (page 11)
- ☐ **COMPLETE & SIGN** Payment Authorization & Agreement (page 12)

Once the above list is completed, please return to Ashley Flynn by fax: (866) 496-3029
or email: aflynn@bostonchildstudycenter.com

This registration packet will be reviewed within 7-10 business days by the clinical team at Boston Child Study Center to ascertain whether our practice is the most appropriate treatment option, after which time you will be contacted regarding the disposition. If you have any questions about completion of this form or our services, you may contact us at info@bostonchildstudycenter.com or (617) 800-9610.

Registration Information

Today's Date: _____

Potential Patient Information (indicate "prefer not to disclose" as desired)
Patient's Legal Name: _____ Age: _____ Date of Birth: _____
Patient's Preferred Name (if different from above): _____
Sex Assigned at Birth: _____ Gender Identity: _____ Pronouns Used: _____
Sexual Orientation: _____
Race: _____ Ethnicity: _____
Which languages are spoken in your home? _____
Which language are you most comfortable speaking? _____
Phone (if applicable): _____ Email (if applicable): _____
Home Address: _____ City: _____ State: ____ Zip: _____
Job/Occupation (if applicable): _____

Caregiver/Guardian Information (if applicable):
Caregiver 1 Name: _____ Occupation: _____
Phone: _____ Type: C/H/W May we leave a message? Y/N
Email Address: _____ Preferred method of contact: _____
Home Address (if different from patient): _____
City: _____ State: ____ Zip: _____
Caregiver 2 Name: _____ Occupation: _____
Phone: _____ Type: C/H/W May we leave a message? Y/N
Email Address: _____ Preferred method of contact: _____
Home Address (if different from patient): _____
City: _____ State: ____ Zip: _____
Marital status: _____ If separated, are legal proceedings in process or anticipated: Y / N
Siblings and ages: _____
Additional individuals living in the patient's home: _____
How did you learn about Boston Child Study Center? _____

Please describe the nature of the problem(s) for which the patient is pursuing services:

Symptoms (e.g., anxiety, depression):	Onset:	Triggers:

Educational History:
Current School (if applicable): _____ Grade/Year: _____

Previous Schools:	Dates of Enrollment:

Has the patient had any special testing or tutoring? Y / N If yes, please indicate and include the most recent report:

Reason for testing/ tutoring:	Dates:	Outcomes/ Recommendations:

Does the patient have or has the patient ever had an IEP, 504, or other accommodation plan? If yes, please describe:

Other school-related concerns: _____

Developmental History (please attach additional pages if needed):

If the potential patient is not your biological child, please indicate...
patient's birth place: _____ your relationship to the patient:_____
how long the patient has been living with you/ in your care: _____
if the patient currently has contact with their birth parents: Y / N If yes, what is the contact agreement? _____

For all completing this form, if known:
Was the patient exposed to antibiotics, medications, alcohol, drugs, or tobacco in utero? Y / N If yes, please indicate:

Was the patient's gestation a full 40 weeks? Y / N If not, please explain: _____

Were there any complications during the pregnancy (e.g., fetal distress, emergency C-section, pre-eclampsia, nuchal cord)? Y /N If yes, please indicate: _____
Were any special services required at the time of the patient's birth (e.g., lights for jaundice, ICU care)? Y /N If yes, please indicate: _____
Were there any concerns/ delays in feeding, sleeping, walking, talking, or motor skills? Y /N If yes, please indicate:

Did the patient participate in Early Intervention services? Y /N If yes, please indicate dates and reason: _____

Describe the patient's social functioning as a toddler: _____
What concerns, if any, are there currently about the patient's ability to socialize/ get along with peers, adults, and family members? _____
Please list notable life events the patient has experienced (e.g., moving, caregiver change in work, change of school, deaths, births, divorce):

Date of Occurrence:	Life Event:	Patient's Response:

Patient Mental Health History (list all diagnoses and attach additional pages if needed):

Past: _____
Current: _____
Has the patient been hospitalized for mental health reasons? Y /N If yes, please indicate:

Dates:	Circumstances/Reason:	Hospital/Program:	Discharge Recommendations:

Has the patient received other mental health services (e.g., therapy, IOP, PHP) ? Y / N If yes, please indicate:

Dates:	Type of Service:	Response to Treatment:	Name/Profession of Provider:

Does the patient have a history of traumatic experiences or abuse? Y / N If yes, please briefly describe/state the traumatic experience(s): _____

Does the patient have a history of self-injury? Y / N If yes, please describe: _____

Does the patient have a history of suicidal behaviors/attempts? Y / N If yes, please describe: _____

Does the patient have access to firearms? Y/N _____

Does the patient have a history of substance use? Y / N If yes, please describe: _____

Past & Current Medications (attach additional pages if needed):

Medication:	Dose & Frequency:	Dates Taken:	Problem Treated:	Response:	Prescriber:

Patient Medical History (list all diagnoses and attach additional pages if needed):

Past: _____

Current: _____

Family Medical History:

Are there any biological family members with medical conditions (e.g., cardiac, diabetes, cancer)? Y / N If yes, please describe:

Relationship to Patient:	Medical Condition:	Treatment/ Other Information:

Family Mental Health History:

Are there any biological family members with mental health conditions (e.g., anxiety, depression, schizophrenia, bipolar, learning disability, autism, ADHD, eating disorder, substance abuse)? Y / N If yes, please describe:

Relationship to Patient:	Mental Health Condition:	Treatment/ Other Information:

Has the patient known anyone who attempted or completed suicide? Y / N If yes, please explain: _____

Is there any legal history including involvement with DCF? Y / N If yes, please describe: _____

CONSENT FOR SERVICES

Welcome to Boston Child Study Center (BCSC). This statement provides important information about the services provided by Boston Child Study Center, practice policies and procedures, and the patient's rights and responsibilities. Please read this document thoroughly and be sure to raise any questions or concerns as soon as is feasible.

Description of the Practice:

Boston Child Study Center specializes in evidence-based treatment for anxiety, behavioral, and mood disorders. As such, the patient's therapist will make every effort to provide the most appropriate evidence-based interventions or will provide the necessary referral information if they are not able to provide such care personally. Boston Child Study Center does not discriminate against any individual on the basis of race, color, ethnicity, religion, sex, age, national origin, sexual orientation, or socioeconomic status.

Nature of Services:

To start, the potential patient and, if applicable, the patient's caregiver(s) will meet for an initial clinical assessment, which may take place over one or more sessions depending on the patient's needs and the discretion of the clinical team. This assessment will help determine the nature of the patient's symptoms, concerns, and difficulties, as well as whether the services provided by Boston Child Study Center are appropriate for the patient's needs. This initial appointment typically consists of meeting with a specialist in the area of concern. The goal of this process is to assess the patient's functioning including the ability to regulate emotions and behaviors, to gather past/current psychological functioning, past/current psychiatric treatment, as well as academic, social, and family functioning in order to determine the best course of treatment. As a training practice, the recommended treatment may include one or more unlicensed/supervised clinicians. If the patient has a current treatment provider, the BCSC therapist may ask for written consent to speak with that person if it is likely to help in making assessment or treatment decisions for care. The full fee for this initial clinical assessment is $450 per scheduled meeting.

After the initial assessment, the therapist will give feedback, make recommendations for further services, and describe various treatment options that may be the best fit for the patient's needs. If the patient is offered services through Boston Child Study Center, we will describe what will be required, what to expect in treatment, and address any concerns or questions. If the patient accepts treatment with Boston Child Study Center, a fee will be set based on the standard fees applicable to the services and provider(s) assigned unless otherwise stated or revised through the sliding scale (see below). The patient will either be placed on a treatment waitlist or begin working with a therapist at the earliest convenience. The patient and, when applicable, caregiver(s) may also request referrals at any time during the treatment process if they are either not interested in waiting for services or do not feel our services are a fit. Boston Child Study Center encourages patients and their families to bring up any questions or concerns during the treatment process, as many issues can be solved effectively together. Patients and their families are free to withdraw from treatment at any time.

As a condition of receiving services with Boston Child Study Center, the patient's personal information will be stored confidentially with Health Insurance Portability and Accountability Act (HIPAA)-compliant electronic medical record software. These databases may also be used for de-identified, retrospective research. Staff at BCSC are committed to developing and advancing effective educational and intervention procedures for patients and, where appropriate, reporting these findings to the professional community. BCSC occasionally uses data contained in a patient's file for archival research, quality assurance checks, and program development. This research is done in such a way that our patients cannot be identified or linked to the data used. If the data is used, it will be de-identified to protect the patient's anonymity and to keep personal records confidential. Information that may be used for research purposes may include details such as the patient's age, diagnosis, de-identified background information (e.g., developmental history, history of presenting concern), detailed course of treatment, and data collected through observation or questionnaires throughout the treatment process.

Policies and Fees:

Boston Child Study Center is an evidence-based, fee-for-service, practice composed of psychologists, neuropsychologists, social workers, mental health counselors, clinical psychology trainees, and trained support professionals. As described above, patients initially meet with a specialist in the area of concern for an initial clinical consultation to determine a preliminary diagnosis, to begin to possibly identify underlying causes of symptoms, to

determine the appropriate level of care, and to identify the best treatment team/program. Our various treatment approaches/ tracks each offer a comprehensive team approach, which may include a combination of individual therapy, individual exposure coaching, individual skills training, parent coaching, family therapy, group therapy, medication management, neuropsychological testing, executive functioning coaching, and/or academic tutoring to address the patient's identified treatment goals. BCSC places a top priority on matching the patient's needs to the appropriate evidence-based treatment and may provide outside referrals if we determine that a better treatment match exists elsewhere.

GROUP POLICIES: DBT Skills Training Groups require a 24-week commitment. Missing 4 groups will result in an individual session to learn the missed group content and reestablish commitment prior to returning to the group. DBT Skills Integration/ Anxiety/ Emotional Processing Groups require a 16-week commitment. Missing 3 groups will result in an individual recommitment session prior to returning to the group. DBT/CBT Skills Training Groups for Parents requires a 12-week commitment and DBT/ACT Skills Training Groups for Parents requires a 15-week commitment. Missing 3 groups will result in an individual session to learn the missed group content and reestablish commitment prior to returning to the group. New members are admitted to the groups on a rolling basis based on availability. Group members may have the opportunity to continue in group for additional sessions if treatment goals are established. Members of DBT Skills Training and Skills Integration Groups for Adolescents and Young Adults are required to be in ongoing evidence-based individual therapy with access to skills coaching. An initial assessment session is required before joining any group. Patients or, when applicable, their caregiver(s)/guardian(s) agree to inform group leaders of any changes in the patient's treatment team. Attendance policies and other group requirements may differ based on the specific group and will be communicated prior to starting in any group.

GENERAL POLICIES: BCSC's service rates are "fee-for-service" as we do not accept insurance. We offer a sliding scale which is granted on a need basis. If the patient wishes to apply for the sliding scale we request that families provide documentation of **total** family income for all parent(s)/step-parent(s)/caregiver(s)/guardian(s) regardless of the patient's age and parent(s')/caregiver(s')/guardian(s') marital status. We also request the number of legal dependents claimed on the tax return, and current out-of-pocket monthly mental health expenses that are not reimbursed for anyone listed on the tax return. If you are not able to provide a tax return, we require submission of any formal paperwork documenting your financial need. After review of these documents, we will determine if the patient qualifies for an adjusted fee, which the patient will then review before deciding whether to proceed with BCSC.

We provide "insurance-friendly" statements that include many of the service codes and information the patient's insurance company may require in order to submit for possible partial "out-of-network" reimbursement. BCSC does not guarantee that any portion of the fees will be reimbursed by the patient's insurance provider. Patients are financially responsible for all services provided by BCSC staff and trainees regardless of the reason for a possible denial or reimbursement. Academic, didactic tutoring, and learning-based services that may augment the patient's overall treatment plan are not eligible for reimbursement by insurance companies. These services will appear on the monthly billing statement with a 00000 code. While BCSC tries to provide patients with the information needed or requested by many insurance companies, we do not work directly with insurance companies nor do we enter into single case agreements. If appeals paperwork or communication is required, the time it takes to complete the paperwork will be billed directly to the patient/ family and will not be covered by the insurance company. Telephone, email, completion of outside paperwork (i.e., paperwork requested for use outside BCSC such as: insurance company, school, etc.), and travel are billed at the patient's therapy services rate and is not reimbursable by the insurance company.

Payments are processed at the end of each month for the balance of the patient's account and can be paid by check, debit card, credit card (Visa, MasterCard, Discover, Amex), or flex-spending debit card. BCSC requires that all clients provide a credit or debit card on file to be used as a primary method of payment. Financial information is stored and processed using PCI-compliant software. After the payment is processed the person responsible for billing will receive a statement via email (unless another method for receiving statements is specified,) which will serve as the receipt of payment. If the patient or caregiver(s)/guardian(s) would like to request a statement citing services rendered and/or the balance on the account prior to the end of the month, please do so in writing at any time by contacting Emily Hartson at ehartson@bostonchildstudycenter.com.

Sample of Standard Fees (lowest qualifying rate to full rate):

- Initial Clinical Assessment: $15 - $450/session
- Ongoing Therapy Appointments for Practice Directors: $15 - $450/session
- Ongoing Therapy Appointments for All Other Therapists: $15 - $375/session
- Group Therapy Intake: $15 - $375/session
- Group Therapy: $15 - $125/session
- Initial Psychiatry Consultation: $15 - $750
- Psychiatry Follow-Up Appointments: $15 - $600/session
- Comprehensive Neuropsychological Assessment: $2,100 - $6,500
- Autism Diagnostic Observation Schedule (ADOS-2): $350 - $1,000
- Professional Training/Talk 1-3 Hours: $750 - $1,400
- Professional Training/Talk 4+ Hours: $2,400 - $4,400
- Executive Functioning Coaching/Academic Tutoring: $15 - $250/session

*Note: Appointments are billed based on the time allotted. If something urgent arises causing the session to run longer than scheduled you'll receive additional charges prorated in 15 min increments. If the session ends early, you will be billed for the full amount of time originally scheduled unless the early termination was due to a clinician conflict or mistake.

*Note: Missed appointments/groups or cancellations made less than 24 hours in advance (except for snow or weather emergencies or documented medical emergencies) are billed at the standard treatment rate. A snow or weather emergency qualifies if the school district in which the patient resides is closed due to weather on the day of the scheduled appointment.

Confidentiality:

All clinical records are kept in a secure electronic medical record or secure filing cabinet. The information provided during the course of the patient's assessment is confidential and will not be revealed outside of Boston Child Study Center without written permission, with a few exceptions that are described below:

- Brief written summaries of each patient contact are required to be kept. These records could be subpoenaed by a court of law under certain conditions;
- If your therapist has reason to believe that the patient or another child/elder/disabled person is being abused, or if the patient has any information regarding such abuse or neglect to another, the therapist is required by law to notify the appropriate child or adult protective agency;
- If the therapist has reason to believe that the patient is at risk of making a serious and/or imminent attempt to hurt or kill themselves or someone else, the therapist is required by law to notify related emergency personnel or victims. In such cases we may be required to complete paperwork with the state involuntarily hospitalizing the patient;
- If there is a criminal or civil legal action related to sanity or competence;
- If the patient or parent(s)/caregiver(s)/guardian(s) initiates legal action or ethical charges against Boston Child Study Center;
- If the patient or parent(s)/caregiver(s)/guardian(s) requests disclosure by signing a release of information form;
- Sometimes children and adolescents may choose to share personal information with the therapist. Typically the specific content of the therapy sessions will not be shared with the parent(s)/caregiver(s)/guardian(s) unless the patient agrees to it or unless it is necessary due to the patient evidencing imminent risk of harm to themselves or to others.

Emergencies:

Boston Child Study Center's clinical hours of practice are typically 9 a.m. to 7 p.m. Monday through Thursday, and 10 a.m. to 6 p.m. on Friday. If the patient's therapist is not available to immediately answer a call during those hours, they will do so as soon as possible during operating hours. Email should only be used for scheduling updates and not used to communicate clinical or personal information (as email is not a secure mode of communication), nor should email, text, or voicemail be used in emergencies. Boston Child Study Center staff has limited availability to respond to crisis situations (e.g., while working with another family, overnight, weekends, holidays, etc.) and for this reason it is crucial that patients are aware of other services available in the community in the event of a crisis or emergency. If the patient experiences a crisis or an emergency, call 911, go to a local emergency room, or call the Statewide Emergency Services Program at 877-382-1609. Upon arrival to the emergency room, the patient and/or caregiver should call the therapist to

provide an update of the status of the emergency care (e.g., name of the hospital, name of provider at hospital, number where the patient can be reached) and BCSC will, at the earliest availability, be in touch with the patient and with the provider upon written or verbal consent for release of information. If the patient or therapist believes that the patient's well being may be at risk due to limitations in the therapist's availability and/or crisis coverage, please let the therapist know both in person and in writing and they will help find a more suitable option to provide care.

TELEHEALTH AT BCSC:

Telehealth is the provision of medical and/or mental health care services using technological modalities in lieu of, or in addition to, traditional face-to-face methods. BCSC utilizes telehealth as a method of delivering treatment services and may be used intermittently throughout the course of in-person therapy or as the primary treatment delivery method. BCSC uses only HIPAA-compliant platforms including but not limited to Google Meet and Zoom (healthcare versions).

I understand that, as with any online communication, there is a risk of loss of confidentiality. The web conferencing platforms being used for my care (Google Meet and Zoom) are HIPAA-compliant and use advanced data encryption technology to minimize the chance of loss of confidentiality. In addition to using a secure web conferencing platform, I understand that my therapist will only conduct sessions from a password-protected network, and that I am encouraged to do the same.

STATEMENT OF AGREEMENT:

Divorced caregivers must each sign this agreement unless documentation to the contrary is provided to Boston Child SC. By providing consent, I am indicating my understanding that:

- the initial clinical assessment will include an evaluation of my current difficulties;
- the initial clinical assessment will help determine the best plan for addressing my or the patient's mental health needs;
- Boston Child Study Center does not ensure that the patient will necessarily be assigned to work with a specific staff member;
- Boston Child Study Center does not ensure that the patient's insurance provider will reimburse for the services rendered with Boston Child Study Center;
- the patient will be given referrals if it is determined that Boston Child Study Center is not a suitable match to address the patient's needs.

I understand that if I have any questions about the assessment, treatment, or their use, I may ask my therapist, Dr. Ryan Madigan, or Dr. Nathan Lambright about them at any time.

By signing this statement I am indicating that:

- I have read Boston Child Study Center's Consent for Services in its entirety;
- I have had any questions or concerns regarding this form addressed by Boston Child Study Center staff;
- I fully understand all information contained therein; and
- I freely agree that I may participate in the services offered.

_____	_____	_____
Printed Name of Patient	Signature of Patient if 18+	Date
_____	_____	_____
Printed Name of Caregiver/Guardian (if applicable)	Signature of Caregiver/Guardian	Date

Online Progress Monitoring at BCSC

Through our commitment to providing the most innovative, evidence-based, and complete care, BCSC has a partnership with Mirah Inc. to provide an online program that monitors you (or your child, as applicable) each week based on treatment goals. This information allows our clinicians to respond with up-to-the-moment treatment refinements. A variety of information may be collected through this platform, including: initial assessment information, weekly goals, and weekly or periodic symptom scales that your clinician determines are relevant to your care. With this information, you and your clinician can make adjustments to care as needed. Your clinician can also review graphs indicating your progress with individual goals, skills mastered, or the presence of specific symptoms.

As scheduled, you will receive a notification to complete a survey via smartphone or computer (usually taking 3-10 minutes). If you are unable to complete the questionnaire(s) prior to your appointment, it may also be completed during your session.

This online measurement is operated by Mirah Inc. Information obtained is treated as confidential and your data is kept in accordance with HIPAA, which provides for data privacy and security provisions. In addition, your data is encrypted and stored on secure servers by Mirah Inc. at all times. Mirah Inc. will use information collected to support your provider and enhance quality assurance procedures at BCSC. Mirah Inc. and your clinical team are committed to advancing mental health care, so your data may be shared in an anonymized form (i.e., not linked to your identifying information) for research and operations purposes. You will not be personally identified in any reports or publications that may result from this survey. As with any means of technology, one possible risk is to privacy.

Providing your consent for online progress monitoring is encouraged as it will assist in clinical care, however it is voluntary and a decision to not provide consent will not adversely affect your relationship with your clinician or the team at the Boston Child Study Center. Please provide first and last names, a preferred cell phone number, **and an** email address where the questionnaires will be sent for each caregiver involved as well as the patient if age-appropriate. If your child does not have an email or phone, a link for any questionnaires to be completed by your child will be sent to Caregiver 1.

Patient full name: _____
Patient cell phone: _____ Patient email: _____

Caregiver 1 full name: _____
Caregiver 1 cell phone: _____ Caregiver 1 email: _____

Caregiver 2 full name: _____
Caregiver 2 cell phone: _____ Caregiver 2 email: _____

AUTHORIZATION FOR EXCHANGE OF INFORMATION

I, _____, authorize clinical communication between Boston Child Study Center staff and
(Caregiver's Name or Patient Name if 18+)

Provider:	Contact Name/Address:	Phone:
PCP/ Pediatrician	_____	_____
Medication Prescriber	_____	_____
Individual Therapist	_____	_____
Family Therapist	_____	_____
School	_____	_____
Parents (if 18+)	_____	_____
Other ( )	_____	_____
Other ( )	_____	_____

Communication may include any and all information in their possession acquired in the course of evaluation and/or treatment of the above named patient. In addition, I authorize the staff of Boston Child Study Center to share information with any emergency caregivers who are involved in the patient's care in the event of a medical or psychiatric emergency. This authorization is voluntary and I have the right to refuse to sign it. I may revoke this authorization at any time by providing written notice of revocation, however such revocation will not affect any action taken by Boston Child Study Center in compliance with this authorization before receipt of a written, hard-copy, revocation. I may accept photocopies or facsimiles of this authorization.

_____	_____	_____
Printed Name of Patient	Signature of Patient if 18+	Date
_____	_____	_____
Printed Name of Caregiver/Guardian (if applicable)	Signature of Caregiver/Guardian	Date

AUDIO/VIDEO RECORDING CONSENT

Video and audio recordings are sometimes used as aids in the therapy process, for the therapist's own personal review of a particular therapy, interview, testing session, or for trainings and professional presentations with other clinicians. Any such recordings will be kept confidential, viewed with discretion, and will only be viewed by the program therapist, clinical supervisors, clinical trainees, and/or training and presentation participants and will not be released to another party without your additional written consent. These recordings will be encrypted and kept in a secure, safe location in accordance with HIPAA regulations. I understand that when I, the patient, am in possession of the recordings off Boston Child Study Center (BCSC) premises (i.e., at home or in another location) it is my responsibility to ensure they are stored safely and securely. As such, I am being asked to read and sign the following:

I, _____ , consent to (check all that apply):

☐ audio ☐ video

☐ clinical use ☐ trainings ☐ professional presentations

This may be done by audio and/or video recording digitally, by cassette, by disc, or by any other means. The purpose and value of recording have been fully explained to me, and I freely and willingly consent to this recording. This consent is being given in regard to the professional services being provided by BCSC.

- I agree that there is to be no financial reward for the use of the recordings. I understand that my consent is completely voluntary and refusal to provide consent will not limit the care I receive at BCSC unless the treatment recommended requires the use of audio/video recording for clinical purposes.
- I understand that I may ask for the recording to be turned off or erased at any time.
- I also understand that at any point following a session, I may choose to request a viewing of the recording with the therapist.
- I further understand that I may then ask for the recording to be destroyed at any point during or after the treatment process. At the time of request, the recording will be destroyed.
- I understand that I am fully responsible for my own participation in any and all exercises and activities suggested by the therapist. I agree not to hold the therapist legally responsible for the effect of these exercises on me, either during the therapy session or later.
- I understand that my therapist is bound by state laws and by professional rules about clients' privacy.
- I hereby give up my rights to any and all interests that I may have in the recordings. I agree to let the therapist and his or her supervisors be the sole owners of all the rights in these recordings for all purposes described above.

OR

☐ I do not consent to recording of any kind.

_____	_____	_____
Printed Name of Patient	Signature of Patient	Date
_____	_____	_____
Printed Name of Caregiver/Guardian (if applicable)	Signature of Caregiver/Guardian	Date

PAYMENT AUTHORIZATION & AGREEMENT

Boston Child Study Center requires all clients to provide a credit or debit card on file to be processed monthly in the amount due on your account. All credit or debit card information is stored in our electronic medical record, which maintains full HIPAA compliance as well as PCI compliance to ensure your personal and financial information is secure, respectively.

We are able to accept flex spending account cards, however if you choose to submit this form of payment you will also be required to submit a second payment authorization with a credit or debit card to be used in the event the flex spending account runs out of funds or is denied for any reason.

We also accept payment via check, which can be mailed or submitted to the front desk at the time of each of your appointments. If you submit payment via check and your account balance is zero at the end of each month your card on file would not be processed. If any remaining balance exists, your card on file will be processed for the outstanding balance.

Debit/Credit Card Authorization:

Please complete the below fields to provide your debit card, credit card, or flex spending debit card to authorize the Boston Child Study Center, LLC to retain your card information on file and enroll your account in our monthly auto-payment system or as a backup payment if you choose to submit payments by check.

Card Type: _____

Cardholder's full name (as it appears on your card): _____

Card Number: _____ Exp: _____ Security Code: _____

Billing Address:_____ City: _____ State: ____ Zip: _____

Billing Phone: _____ Email to send statements/receipts: _____

Authorization:

I hereby authorize Boston Child Study Center to charge the indicated credit/debit card in the amount due on my account. I guarantee and warrant that I am the legal cardholder for this credit/debit card.

_____	_____	_____
Printed Name of Cardholder	Signature of Cardholder	Date