Patient Rights & Consent for Psychotherapy, Mental/Behavioral Health Counseling Treatment

I hereby consent to *mental health treatment / psychotherapy* for: ________ *Patient Name* ________, born on ________ *Date of Birth*,

counseling may also include: ☐ My Family; ☐ Other(s) *& Dates of Birth*: ____________________

____

(Counseling or Therapy may be individual, family, couple or group treatment) MOBILE PHONE# ____________________

HOME#

____

PATIENT ADDRESS *CITY* *ST.* *Zip* ***email*** *(optional)* *(*Indicate if you do NOT want messages left)

PATIENT'S **PHYSICIAN**: ____________________

❑ I request & permit this agency, ***Resolving Concerns / Mark R. Young Inc.*** to share a treatment summary with my **physician** ________ *INITIALS*

REFERRED By (who recommended me?):____________________; I want my referral source to know I attended ❑YES; ❑NO

MAIN CONCERN or GOAL for COUNSELING (Optional): ____________________

____

ARE YOU CURRENTLY HAVING SUICIDAL THOUGHTS? ◻ **NO;** ◻ **YES** (please be sure to discuss this)

I understand that my treatment records & clinical information will be kept confidential and that information about my involvement here will not be released without my authorization to anyone outside of this clinic, except as outlined below under "EXCEPTIONAL SITUATIONS"; laws and/or ethical guidelines may mandate this reporting to *law enforcement and/or Dept. of Human Services.*

The treatment may include clinical supervision by *Mark R. Young, LMSW, LCSW / Resolving Concerns (*not always), and sharing of insurance/billing information with on or off-site contracted office staff, or collection agency.

EXCEPTIONAL SITUATIONS *in which my clinical and other information might be shared and/or NOT kept confidential:*

- A human life is potentially in great danger, such as someone intending to suicide or seriously harm someone else.
- A child (or handicapped adult) is suspected of being in danger of being or having been abused or neglected physically, sexually, or psychologically.
- I sign a consent form giving this clinic/staff my permission to share information about me, or to request information about me. (I can cancel any signed consent any time prior to the expiration).
- A court order or subpoena is issued.
- I fail to honor my financial obligations for services received

I have the right to know names & qualifications of staff treating me, to discuss my treatment progress, goals, to view records (or receive photocopies for a fee). I understand that this agency (Resolving Concerns / Mark R. Young Inc.) may terminate my treatment at any time for non-compliance, conflict of interest, or his professional discretion, at any time without advanced notice. I understand that staff availability and emergency services are limited, and I'm aware my community emergency resources include 911/law enforcement, hospital Emergency departments, & community mental health, I will utilize these resources if necessary in an emergency. I agree to pay for services received, including any services not covered by health insurance.

If you have any questions, please ask someone before signing this form

____________________ ____________________

Patient (or Parent /Guardian) Signature(s) *Date*

____________________ ____________________

TREATMENT PROVIDER *Date*

Continue on the NEXT SIDE ➾

Financial Agreement for Psychotherapy/Counseling Services *(Please READ CAREFULLY)*

I agree to be financially responsible for all treatment service costs provided by this agency, *Resolving Concerns / Mark R. Young Inc., employees* or associates, even if not covered by insurance. I agree to give at least ***24 hour notice*** if I can not attend a scheduled appointment, and I agree to the following (*rates are subject to change & maybe differ according to network contracts)*:

Initial Assessment *(45-60min):* **$175** ***Individual Therapy*** *(38-52min):* **$100** ***Family Therapy*** *(45-50min):* **$120**
Extended Session *(53-60min):* **$130** ***Bounced check:*** **$25** ***No-Show or Late Cancel*** *(< 24hrs)*†***:*****$25/$50/full**
Other rates may apply to *Telephone Consultation, Requested Reports, Email, written Correspondence* or other services.

Financial hardship discount *(if offered; requires pre-payment)*: $ ___________

† 1st time 25%; 2nd time 50%; 3rd time full session cost. If you miss an appointment, the entire clinical hour is lost, preventing other patients from being seen. This is your responsibility, as health insurances do not cover missed appointments. I believe your time is just as valuable: If I double book, late cancel or forget your appointment, I'll compensate you the same.
(Does not apply to Medicaid patients per state law; treatment is terminated instead)

I will be solely responsible for these fees and any other charges not covered by my medical or health insurance.
*If I refuse or fail to honor these agreements, I authorize this agency to refer & release my account and my demographic and billing information to a **collection service**, and agree to cover any related collection fees (40-50% of balance is typical; additional small claims court fees may also be assessed), & understand my treatment/services may be **terminated**.*

I agree to pay for any and all services not paid by insurance (Patient, Parent or Responsible) party: ____________
INITIALS

*I agree to pay the fee for any **missed**, **no-showed** or **late-canceled** appointments:* ____________
INITIALS

HIPAA - I acknowledge the posted Notice of Privacy Practices & that I may have a paper copy if requested: ____________
INITIALS

Consent to Release Information & Submit Bills to Health Care Plan

I hereby give *RESOLVING CONCERNS and MARK R. YOUNG, INC.* full permission to submit **any** required information about me to my health insurance plan, EAP, or other form of coverage I provide.

______________________; __________; ______________________; ______________________
RESPONSIBLE PERSON (*Name)* ***INITIALS*** ***SSN (Optional)*** ***DATE OF BIRTH***

______________________; __________; ______________________; ______________________
INSURED NAME ON CARD ***INITIALS*** ***SSN (Optional)*** ***DATE OF BIRTH***

____ ______________________
PRIMARY *INSURANCE company* *Policy #* *Group#*

____ ______________________
SECONDARY *INSURANCE company* *Policy #* *Group#*

PATIENT'S RELATIONSHIP TO INSURED: ❑ SELF; ❑ CHILD; ❑ SPOUSE; ❑ OTHER; ______________________
Insured's Employer

AUTHORIZATION NUMBER (if any): ______________________ Mail Claims to:______________________

CURRENT MEDICATIONS or RELEVANT MEDICAL CONDITIONS: ☐ NO MEDICATIONS; ☐ NO MEDICAL PROBLEMS

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REV. 29MAR2017