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

I hereby consent to *professional mental health counseling* 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) TEL. CELL#: _____

HOME#:

Patient Address *City* *ST.* *Zip* ***email*** *(optional)* *(*Indicate if you do NOT want messages left)

PATIENT'S **PHYSICIAN**: _____; ❑ Please share a treatment summary with my **physician**

INITIALS

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

Consent to Release Information & Submit Bills to Health Care Plan

I hereby give *RESOLVING CONCERNS & MARK R. YOUNG, INC.* permission to submit my information to my health plan or other coverage.

_____; _____; _____; _____ ❑M; ❑F

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

_____; _____; _____; _____ ❑M; ❑F

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: _____

You have the right to know names & qualifications of staff treating you and to discuss treatment progress, goals, view records (or receive photocopies for standard fee). I understand my treatment maybe be terminated at any time for non-compliance, conflict of interest, or professional discretion, at any time without advanced notice. I understand that staff availability and emergency services are limited, and I'm aware **emergency** resources include 911/law enforcement, hospital Emergency departments, & community mental health. I agree to pay for services received, including any services not covered by health insurance.

Financial Agreement *(Please READ CAREFULLY)*

I agree to be financially responsible for all treatment costs not covered by insurance. I agree to give at least ***24 hour notice*** if I can not attend a scheduled appointment, and agree to the following (*rates are subject to change & some differ according to network contracts). If I refuse or fail to honor these agreements, I authorize this agency to release my account, demographic and billing information to a* ***collection service****, and agree to cover any related collection fees (40-50% of balance is typically charged; additional small claims court fees may also be assessed), & understand my treatment/services may be* ***terminated****.*

Initial Assessment *(45-60min):* **$175** ***Individual Therapy*** *(38-52min):* **$100** ***Family Therapy*** *(45-50min):* **$120**

Extended Session *(53-60min):* **$140** ***Bounced check: $25; NO-SHOW OR LATE CANCEL*** *(<24hrs)*† **$35-$140**

†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. Your time is just as valuable: If we late cancel or forget your appointment, we'll compensate you the same. *(Does not apply to Medicaid patients per state law requiring treatment is termination instead)*

Other rates may apply to Telephone Consultation, Requested Reports, Email, written Correspondence or other services.

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

I consent to private or clinical information sent to me via: ❑*TEXT MESSAGES;* ❑*VOICEMAIL / MESSAGES;* ❑*US MAIL* _____
INITIALS

I consent to using TeleHealth, Telephone and/or Video technology if I choose to receive services away from the office/clinic _____
INITIALS

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

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

:
I understand my treatment may be considered "closed / discharged" 30 days beyond last visit w/o expressed intent to continue _____
INITIALS

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

_____

_____

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

TREATMENT PLAN: ***MAIN CONCERNS, PROBLEM, and/or GOALS for COUNSELING***: _____

_____

Expected Duration: _____

I understand that my treatment records & clinical information will be kept confidential and that information about my involvement here will not be released outside this clinic without my authorization, 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

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

_____ _____

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

_____ _____

TREATMENT PROVIDER *Date*