Print Form

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PATIENT CONSENT TO PSYCHOLOGICAL TREATMENT

INTRODUCTION: Thank you for scheduling an appointment with me for psychological services. There are a few policies about my practice that would be helpful for you to know before you consent to treatment and/or evaluation. Please take a few moments to read them. Before we begin our session, I will review these policies with you and will answer questions that you may have.

CONFIDENTIALITY: I understand that anything said between the psychologist and any client must be held in strict confidence with the following three exceptions: 1) a requirement by law to report to DHS any knowledge or suspicion of abuse or neglect of children or elderly or handicapped persons; 2) an ethical requirement to take action if a person's life is in danger through intent of suicide or homicide; 3) consultation with professional colleagues omitting names and identifying information; and if the client is a child under the age of eighteen (18), the psychologist may speak with the parents with the child's knowledge without revealing any specific confidences.

If I wish to have information about my treatment or evaluation sent to another service provider or to an insurance company, I will be asked to sign a written release of information request. I am aware that if I consent to an evaluation that is requested and/or paid for by a third party, the results of the evaluation will be sent to the third party. I understand that it may be necessary to share information with my insurance company in order to request additional sessions or to process payments for services.

BILLING: Payment for services rendered is due at the time of each session. While most medical insurance policies help to pay for the services, I understand that I am required to pay the co-pay and/or deductible at the time of the session. With out-of-state insurance providers, full payment is due at the time of service and a reimbursement form will be submitted. If for any reason my insurance company fails to pay, I understand that the bill is my responsibility. The sessions are scheduled based upon the 45-minute standard. Assessment involves the administration of tests and the total number of hours devoted to the case which includes time spent with the client plus the time spent scoring and interpreting the tests as well as generating the report. Thus, the number of hours billed will be greater than the time spent in the office taking the tests. If I fail to pay my bill I am aware that a collection agency and/or small claims court may be used. Psychotherapy services are billed at the rate of $150.00 per hour.

I authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this account authorizes my provider to submit claims for benefits, for services to be rendered, without obtaining my signature on each and every cleaim to be submitted for myself and/or dependents. I agree that I will be bound by this signature (below) as if I had personally signed the particular claim.

APPOINTMENTS: Since appointments are scheduled only for a specific client for that time period, I understand that I must pay $50.00 for failure to appear for a session or failure to cancel with less than 24 hours notice. I understand that missed appointments cannot be billed to my insurance company. Frequently missed or cancelled appointments may result in the termination of psychotherapy.

I am aware that the practice of psychology is not an exact science and I acknowledge that no guarantees have been made to me as to the results of treatment or assessment. I have read and understand the above policies. I have been given an opportunity to ask questions and to discuss any issues with the psychologist.

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Print Name / Signature Date Reviewed

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