TREATMENT AND CONSULTATION
A PROFESSIONAL PSYCHOLOGICAL CORPORATION
SEAN O'HARA PSY.D, NCAC, SAP
CONSENT TO TREATMENT/ MENTAL HEALTH DISCLOSURE FORM

FINANCIAL TERMS: INSURANCE COVERAGE AND CO-PAYMENTS N/A

YOU ARE RESPONSIBLE FOR OBTAINING AUTHORIZATION FOR TREATMENT FROM YOUR INSURANCE CARRIER. WE WILL BILL YOUR INSURANCE, HOWEVER, YOU ARE RESPONSIBLE FOR COPAYMENT AMOUNTS AND DEDUCTIBLES AS SET FORTH BY YOUR BENEFIT PLAN. THESE PAYMENTS ARE DURE AND PAYABLE AT EACH APPOINTMENT. **INITIAL HERE**_____

ASSIGNMENT OF BENEFITS

I AUTHORIZE MY INSURANCE CARRIER TO DIRECTLY PAY MY PRACTITIONER. **INITIAL HERE**_____

CANCELLATION AND MISSED APPOINTMENT POLICY

SCHEDULED APPOINTMENT TIMES ARE RESERVED ESPECIALLY FOR YOU. IF AN APPOINTMENT IS MISSED OR CANCELLED WITHIN 24 HOURS NOTICE, YOU WILL BE BILLED THE FULL SESSION CHARGE. THESE FEES ARE NOT COVERED BY YOUR INSURANCE CARRIER AND THE CHARGES ASSOCIATED WITH THEM ARE YOUR RESPONSIBILITY. REPEATED "NO SHOW" OR "CANCELLED" APPOINTMENTS COULD RESULT IN YOU BEING REFERRED BACK TO YOUR INSURANCE COMPANY FOR REASSIGNMENT TO ANOTHER PRACTITIONER OR TERMINATION AS A PATIENT.

INITIAL HERE_____

LIMITS OF CONFIDENTIALITY STATEMENT

ALL INFORMATION BETWEEN PRACTITIONER AND PATIENT IS HELD STRICTLY CONFIDENTIAL. THERE ARE LEGAL EXCEPTIONS TO THIS AS FOLLOWS:

1. THE PATIENT AUTHORIZES A RELEASE OF INFORMATION WITH A SIGNATURE.
2. THE PATIENTS MENTAL CONDITION BECOMES THE ISSUE IN A LAWSUIT.
3. THE PATIENT PRESENTS A PHYSICAL DANGER TO SELF OR OTHERS.
4. CHILD OR ELDER ABUSE IS SUSPECTED
5. AS NECESSARY FOR CONTINUITY OF CARE

IT IS UNDERSTOOD THAT IN CASES #2, #3 AND #4 A PSYCHIATRIST OR PSYCHOLOGIST IS REQUIRED BY LAW TO INFORM POTENTIAL VICTIMS AND LEGAL AUTHORITIES SO THAT PROTECTIVE MEASURES CAN BE TAKEN. ALL WRITTEN AND SPOKEN MATERIAL FROM ANY AND ALL SESSIONS IS CONFIDENTIAL UNLESS WRITTEN PERMISSION IS GIVEN TO RELEASE ALL OR PART OF THE INFORMATION TO A SPECIFIC PERSON, PERSONS OR AGENCY. IF GROUP THERAPY IS UTILIZED AS PART OF THE TREATMENT, DETAILS OF THE GROUP DISCUSSION ARE NOT TO BE DISCUSSED OUTSIDE OF THE COUNSELING SESSIONS. **INITIAL HERE**_____

RELEASE OF INFORMATION

I AUTHORIZE THE RELEASE OF INFORMATION TO MY PRIMARY CARE PHYSICIAN OR PSYCHIATRIST OR OTHER HEALTHCARE PROFESSIONALS AND REFERRALS SOURCES FOR THE PURPOSE OF DIAGNOSIS, TREATMENT, CONSULTATION AND PROFESSIONAL COMMUNICATION. IF I AM AN INSURED PATIENT, I FURTHER AUTHORIZE THE RELEASE OF

INFORMATION FOR CLAIMS, CERTIFICATION AND CASE MANAGEMENT, QUALITY IMPROVEMENT PURPOSES RELATED TO MY HEALTH PLAN. **INITIAL HERE**_____

APPEALS AND GRIEVANCES

I ACKNOWLEDGE MY RIGHT TO REQUEST A RECONSIDERATION (AN APPEAL) IN THE CASE THAT OUTPATIENT IS NOT CERTIFIED. I UNDERSTAND THAT I WOULD REQUEST AN APPEAL DIRECTLY THROUGH MY PROVIDER AND THAT I RISK NOTHING IN EXERCISING THIS RIGHT. I ALSO ACKNOWLEDGE THAT I MAY SUBMIT A GRIEVANCE TO THE PROVIDER OR ADMINISTRATOR AR ANY TIME TO REGISTER A COMPLIANT ABOUT ANY ASPECT OF MY VCARE OT I AMY SEND THE COMPLAINT DIRECTLY TO MY INSURANCE COMPANY. **INITIAL HERE**_____

EMERGENCY ACCESS

A COVERING PRACTITIONER OR I AM AVAILABLE AFTER HOURS TO HANDLE EMERGENCIES. BY CALLING THE MAIN OFFICE NUMBER DURING AFTER HOURS YOU WILL BE INSTRUCTED HOW TO CONTACT THE PRACTITIONER OR EMERGENCY SERVICES INCLUDING 911. PLEASE DO THIS FOR TRUE LIFE THREATENING EMERGENCIES ONLY. THERE MAY BE A CHARGE FOR TELEPHONE CONSULTATIONS THAT REQUIRE 10 MINUTES OR LONGER DEPENDING ON CIRCUMSTANCES.

INITIAL HERE_____

CONSENT FOR TREATMENT

I AUTHORIZE AND REQUEST MY PRACTITIONER TO CARRY OUT PSYCHOLOGICAL AND/OR PSYCHIATRIC EXAMS, TREATMENT AND/OR DIAGNOSIS PROCEDURES, WHICH NOW, OR DURING THE COURSE OF MY TREATMENT BECOME ADVISABLE. I UNDERSTAND THE PURPOSE OF THESE PROCEDURES WILL BE EXPLAINED TO ME UPON MY REQUEST AND THAT THEY ARE SUBJECT TO MY AGREEMENT. I ALSO UNDERSTAND THAT WHILE THE COURSE OF MY TREATMENT IS DESIGNED TO BE HELPFUL, MY PRACTITIONER AN MAKE NO GUARANTEES ABOUT THE OUTCOME OF MY TREATMENT. FURTHER, THE PSYCHOTHERAPEUTIC PROCESS CAN BING UNCOMFORTABLE FEELINGS AND REACTIONS SUCH AS ANXIETY, SADNESS AND ANGER. I UNDERSTAND THAT THIS IS A NROMAL RESPONSE TO WORKING THROUGH UNRESOLVED LIFE EXPERIENCES AND THAT THESE REACTIONS WILL BE WORKED ON BETWEEN MY PRACTITIONER AND ME. **INTIAL HERE**_____

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PATIENT OR GUARDIAN SIGNATURE **DATE**

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PSYCHOLOGIST SIGNATURE **DATE**

GENERAL CONSENT OF A CHILD OR DEPENDENT'S TREATMENT

I AM THE LEGAL GUARDIAN OR LEGAL REPRESENTATIVE OF THE PATIENT AND ON THE PATIENTS BEHALF LEGALLY AUTHORIZE THE PRACTITIONER TO DELIVER MENTAL HEALTH CARE SERVICES TO THE PATIENT. I ALSO UNDERSTAND THAT ALL POLICIES DESCRIBED IN THIS STATEMENT APPLY TO THE PATIENT I REPRESENT.

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PATIENT NAME **DATE OF BIRTH**

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SIGNATURE OF LEGAL GUARDIAN/REPRESENTATIVE **DATE**