TREATMENT AND CONSULTATION
A PROFESSIONAL PSYCHOLOGICAL CORPORATION

SEAN O'HARA PSY.D, NCAC, SAP
CONSENT TO TREATMENT/INFORMED CONSENT
PSYCHOLOGICAL TREATMENT/TESTING CONSENT
MENTAL HEALTH DISCLOSURE FORM

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

DR. O'HARA IS NOT CONTRACTED WITH ANY INSURANCES AND FEE FOR SERVICE IS TO BE MADE AT TIME OF SERVICE. TREATMENT AND CONSULTATION BILLING SERVICE WILL SUBMIT TO THE PATIENT A SUPER BILLING STATEMENT (SBS) FOR THE PATIENT TO SUBMIT TO THE INSURANCE COMPANY WITH ONE OF THEIR CLAIMS FORMS FOR REIMBURSEMENT. MOST PPO/EBO COVER AN OUT-OF-NETWORK BETWEEN 50% TO 100%.

PATIENTS SHOULD CHECK WITH THEIR INSURANCE COMPANIES PRIOR TO THE VISIT TO INQUIRE WHAT REIMBURSEMENT CAN BE OBTAINED **INITIAL HERE**_____

ASSIGNMENT OF BENEFITS

ANY REIMBURSEMENTS RECEIVED BY DR. O'HARA FROM INSURANCE COMPANIES WILL BE IMMEDIATELY RETURNED TO THE PATIENT IN FULL. 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 CAN AUTHORIZE THE RELEASE OF INFORMATION BY DR. O'HARA TO ANY PERSONS **ONLY WITH A SIGNED RELEASE OF INFORMATION FORM**. **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 AS SOON AS A GRIEVANCE OCCURS OR TO REGISTER A COMPLIANT ABOUT ANY ASPECT OF MY CARE AND SEND THE COMPLAINT DIRECTLY TO MY INSURANCE COMPANY. **INITIAL HERE**_____

EMERGENCY ACCESS AND COMMUNICATIONS

A COVERING PRACTITIONER OR DR. O'HARA IS 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**_____

EMAIL AND TEXTS MESSAGES ARE UTILIZED PRIMARILY FOR SCHEDULING OF APPOINTMENTS, CHANGES IN SCHEDULING, LOGISTICS RELATED TO PSYCHOTHERAPY AND BRIEF REINFORCEMENTS OF PREVIOUSLY DISCUSSED IN SESSION CONTENT FOR THE PURPOSE OF CONFIDENTIALITY AND CLARITY AND PATIENT PROTECTION. EMAILS AND TEXTS ARE NOT FOR HIGH THERAPEUTIC CONTENT OR DISCUSSION OF EMERGENT CONDITIONS
INITIAL HERE_____

TELE-HEALTH AND PHONE CONSULTATION

DR. O'HARA PROVIDES eTHERAPY AND PHONE CONSULTATION WHEN APPROPRIATE FOR PATIENTS WHO NEED ONGOING SUPPORT AND CANNOT MAKE AN OFFICE APPOINTMENT OR IS A PATIENT TRAVELING OR WHO LIVE IN OTHER STATES. PT.'S WHO ARE IN HIGH CRISES MAY NOT BE ACCEPTABLE FOR TELE-HEALTH AND WILL BE REFERRED TO EMERGENT SERVICES. ALL TELE-HEALTH AND PHONE CONSULTATIONS ARE SUBJECT TO CONFIDENTIALITY. I UNDERSTAND THE USE OF TELE-HEALTH AS AN ACCEPTABLE MODE OF DELIVERING HEALTH CARE SERVICES AND MENTAL HEALTH
INITIAL HERE_____

TERMINATION OF TREATMENT

WHEN PATIENT GOALS HAVE BEEN MUTUALLY AND ACCEPTABLY MET TREATMENT TERMINATION CAN BE MADE. EITHER DR. O'HARA OR THE PATIENT MAY TERMINATE TREATMENT AT ANY TIME DEEMED NECESSARY BY EITHER PARTY. PATIENT REFERRED TO HIGHER LEVELS OF CARE OR UNDER NEW PRACTITIONERS ARE TERMINATED AS TO NOT CONFUSE TREATMENT GOALS. **PATIENT'S WITH NO IN-SESSION PSYCHOTHERAPY FOR OVER 3 MONTHS OR LONGER ARE CONSIDERED INACTIVE AND DISCHARGED FROM CARE AND MAY RESUME TREATMENT UNDER A NEW TREATMENT PLAN IF THEY ARE APPROPRIATE FOR PRIVATE PRACTICE OUTPATIENT LEVEL OF CARE INTIAL 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 CAN MAKE NO GUARANTEES ABOUT THE OUTCOME OF MY TREATMENT. FURTHER, THE PSYCHOTHERAPEUTIC PROCESS CAN BRING UNCOMFORTABLE FEELINGS AND REACTIONS SUCH AS ANXIETY, SADNESS AND ANGER. I UNDERSTAND THAT THIS IS A NORMAL RESPONSE TO WORKING THROUGH UNRESOLVED LIFE EXPERIENCES AND THAT THESE REACTIONS WILL BE WORKED ON BETWEEN MY PRACTITIONER AND ME.

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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**