Authorization to Treat, Authorization to Treat Minor Child, Fees, Professional Disclosure Information (HIPAA) & Client Rights

Authorization to Treat

I give my consent, to my therapist, to provide assessment and therapeutic services to me/my child, within the scope of his/her license. I understand that my therapist will work with me to develop a treatment plan and treatment will be formulated to resolve my problem(s) as quickly as possible. I agree to cooperate with my therapist in the treatment process to carry out therapeutic homework assignments and to follow through with any medical treatment, as prescribed by my physician. I further agree to keep my or my child's scheduled appointments and understand failure to do so more than two times may result in my care being terminated.

Name of Client/Child_______________________________________Date of Birth_______________________

I warrant that I am a custodial parent of the above named minor child. I hereby give permission for him/her to receive counseling. I acknowledge that I am aware of the mandating reporting laws in the State of Missouri. I am also aware that I can withdraw the permission to treat my child at any time. I will assume responsibility to notify my child's other parent that counseling has been initiated and will take sole responsibility in arranging for the payment for all counseling services for my child.

Cancellations/Fees

A 24-hour notice is required for all cancellations. Otherwise, a **fee of $55 will be charged** for the missed appointment. Insurance companies do not pay for missed appointments; therefore this charge will be the patient's or guardian's responsibility.

FEES	
Initial Interview	**$125.00**
Individual Psychotherapy (45-50 minutes)	**$110.00**
No Show/Late Cancellation	**$ 55.00***
FMLA/Letters to Physicians, Employers, Schools	**$110.00/hour***
Reports/Court Testimony (includes all required time)	**$500.00/hour***

***Fees not covered by insurance**

Client Rights

YOU HAVE THE RIGHT:

1. To be treated with consideration and respect.
2. To expect quality services provided by concerned, competent staff.
3. To a clear statement of purposes, goals, techniques, rules of procedure and limitations, as well as potential dangers of the services to be performed, plus all other information related to or likely to effect the on-going counseling relationship.
4. To obtain information about the case record and to have the information explained clearly and directly.
5. To full knowledgeable and responsible participation in the on-going treatment plan.
6. To expect complete confidentiality and that no information will be released without my written consent.
7. To see and discuss charges and payment record.
8. To refuse any recommended services and to advised of the consequences of this action.

CONFIDENTIALITY OF INFORMATION

Laws, insuring your right to privacy, protect matters discussed with your therapist. In most cases, your therapist is prohibited from disclosing information about your care without your written consent and then only to the extent you authorize. Cases where information may be disclosed <u>without your consent</u> include:

1. When child abuse is known or suspected (reporting is required by law).
2. When the abuse of an elderly or dependent person is known or suspected (required by law).
3. If you commit a crime against a staff member or another person on the premises.
4. If there is a situation that is potentially life threatening.
5. When records are subpoenaed by the court.

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SECURITY OF RECORDS

Your treatment of records and related financial records are kept in secured area. Records will not be made available to others without a signed authorization to release information. Special rules relating to release of treatment records containing information regarding drug and alcohol abuse: CFR 42, PART 2, prohibits disclosure of such information without written consent of the client and only to the extent specifically authorized. A general release for medical or other information is not sufficient. Use of information in records for criminal investigation and prosecution is prohibited.

RETENTION OF RECORDS

Treatment records are retained for a period of seven years following the termination of treatment for adults and until ages 28 in the case of minors. At the end of that period the records are destroyed in a manner that assures the confidentiality of the information unless the client requests otherwise, in writing, prior to the destruction of records.

INFORMATION REGARDING PSYCHOTHERAPY

1. Psychotherapy may involve remembering unpleasant events and can arouse intense emotions of fear and anger, feeling of anxiety, depression, frustration, loneliness or helplessness, which may be experienced. Also, feeling of relief, energy, power, self-acceptance and well-being may also occur.
2. Psychotherapy is not always effective and may, in some cases; result in deterioration rather than improvement of a client's psychological functioning.
3. There are numerous forms of psychotherapy, which vary, not only underlying theory and methods employed, but also in terms of time commitment and cost. We will attempt to provide treatment that is realistic in both areas.
4. Current research has failed to demonstrate that any one form of psychotherapy is necessarily more effective than any other.
5. Depending upon a client's condition, there may be available alternatives to psychotherapy, such as medication or behavior modification. We will make these recommendations of they are appropriate, based upon our assessment.

I certify that I, and/or my dependent(s) have insurance coverage and assign directly to my therapist all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. My assigned therapist may use my health care information and may disclose such information to my insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits for the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the dated signed below. I am responsible for notifying my therapist immediately upon any change of insurance coverage.

By signing below, I agree to payment and arrangements set forth, affirm that all my questions have been satisfactorily answered, and give informed consent for myself/my child's treatment. I understand that I will be furnished a copy of the consent whenever I request it. Your signature below indicates that you have read our HIPAA agreement and agree to its terms and serves as acknowledgement that you have received our HIPAA notification form. Not a biding by these policies may lead to termination of our work together and/or referral to another professional.

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Client Signature/Responsible Party   Date