Client / Therapist Agreement Consent and Assignment for Insurance Benefits

Now, please take a moment to read this overview of mental health services and indicate that you understand our policies by checking each box as you read it.

Confidentiality

[ ] Under state and federal law, your counseling records are protected. Thus, the content of our sessions is strictly confidential. Information about you cannot be released without your written consent. However, under mandated law, there are exceptions to this confidentiality. These exceptions include threat to harm self or others, gravely disabled, child abuse/neglect situations, aging adult abuse/neglect, and court orders from a judge to release information. Additionally, insurance carriers often request and require oral or written case summaries as a condition of reimbursement. Also, if you were referred to me by another professional, we would like to notify them of your contact with us, unless you instruct us otherwise.

[ ] Fees and Billing Policy

All fees are charged at the time services are rendered; however, we bill your insurance on a monthly basis. In general, all sessions are billed per 45 minute ("clinical hour") session. Different fee schedules exist for longer evaluations, testing, expert witness fees, consultations, and test interpretations. You may pay by cash, check, cashier's check, or money order. Upon payment of cash, you will receive a receipt to keep for your records. In the event that a check should be returned, you will be responsible for paying any fees that are charged by the banking company, in addition to the original amount owed. (This payment may be made by cash or cashier's check only). Account balances that exceed $500 will need to be reviewed with your therapist before scheduling further appointments.

[ ] Insurance Billing Policy

If you choose to use your insurance plan, you will be encouraged to pay for services rendered at the time of service. If you are unable to pay the full amount, review your financial concerns with your therapist. Please be aware that if you do elect to assign your health benefits, your insurance company will require that we submit diagnostic and clinical information. While such information is very sensitive and generally treated as such by insurance carriers, we cannot guarantee how any particular insurance carrier or employer will treat your information. Additionally, there will be times that your insurance company will seek more information before giving further authorizations for reimbursement.

[ ] Authorization to Release Information and to Pay Benefits

By signing below, I agree to authorize Fresno Mental Health Services to release any of my behavioral health information, including any drug and alcohol history, to my insurance company, as needed to process my insurance claim. In addition, I authorize my insurance company to make payments directly to Fresno Mental Psychological Health Services, PC for covered behavioral health services. I understand information to be released will include both written and verbal communications of confidential records regarding psychiatric and/or substance abuse treatment. This will include but, not limited to: dates of treatment and charges. In addition, copies of my medical records may be provided, if required. I understand this information is to be released for the purpose of receiving insurance benefits and/or payments for utilization review purposes in determining justification for admission, continued stay and changes in levels of care throughout your treatment. Information released is not to be further disclosed for any purpose other than that stated in this authorization. It is understood that I have the right to revoke this consent in writing at any time. Any revocation shall be signed by us, and the signature witnessed by a person who can attest to my identity. No written revocation of consent shall be effective until it is received by the person otherwise authorized to disclose records and shall have no effect on disclosures made prior thereto. I understand that I have the right to inspect and /or receive a copy of the information released.

[ ] Appointments

Services are provided by appointment only. In as much as possible, we will work with you on providing convenient appointment times. The length of the appointment is generally scheduled for 45-50 minutes, allowing 10-15 minutes of the hourly charge for preparation and record keeping.

[ ] **A 24-hour notice for cancellations is required, otherwise you will be charged.** We know that unpredictable circumstances do arise and we will allow for an emergency cancellation for which you will not be charged, upon our discretion. Please be aware that insurance carriers do not reimburse for missed appointments. If you know that you will need to cancel an appointment, please call and we will work together on rescheduling your session at a more convenient time and date. In the event that you arrive late for an appointment, only the remainder of that appointment time can be carried out. With this policy, it is intended that you, as well, will not be inconvenienced and seen later than scheduled by a previous client's late arrival.

[ ] Messages

Please note we do not accept calls while in session. During those times, or when we are out of the office, messages can be left with the office staff or on our voice mail. We will make every effort to return your call in a timely manner. **Please note, Fresno Mental**

Psychological Health Services, PC does not use email or text to convey or receive clinical information! Please complete each page and email your **PDF** to: Psychologist@FresnoPsychServices.com.

[ ] Confirmation of Appointments

By signing below, I agree that Fresno Mental Health Services contact me at the following number(s) to confirm, make, or change appointments:

I (Your Name) _____ Date of birth: ____/__/_____

Address: _____City: _____State: _____Zip:_____

Your Phone #:_____ Email Address:_____

Policy Holder's SSN#_____ Insurance Company:_____

Policy #:_____ Group #:_____

EAP#::_____ Emergency Person #:_____

I also [ ] **agree**/ [ ] **don't agree** (please check one) to allow Fresno Mental Psychological Health Services, PC to leave a message regarding our appointment, if I am not available at the time of the call.

***** THIS FOLLOWING SECTION WILL BE FILLED OUT IN PERSON *****

Monthly Statements

By signing below, I agree to authorize Fresno Mental Health Services to send monthly statements to my provided home address, as well as provided email addresses, in the event that I have a balance owed.

Consent for Treatment

By signing below, I acknowledge that I have read the Notice of Private Practice as part of the HIPPA Policy requirements. If you have any questions or concerns regarding any of this material, please do not sign until we have discussed it and I have answered all of your questions. I understand that my refusal to consent to the release of the information specified above will prevent disclosure of such information to the person(s) and/or agency named herein, which may result in denial of insurance benefits and/or payments. Therefore, I further understand that I am responsible for payment of any and all changes by Fresno Mental Psychological Health Services, P.C. and its affiliates.

_____ _____

Patient Signature Responsible Party's Signature (if patient's under 18)

_____ _____

Printed Name of Patient Printed Name of Responsible Party

_____ _____

Witness Signature (For office use only) Date

_____

Printed Name of Witness

I hereby assign payment directly to the above named provider of all or any individual/group health plan benefits and otherwise payable to Fresno Mental Psychological Health Services, PC but not to exceed the balance due to the provider's regular charges for this period of treatment. I also assign any available major medical benefits.

* Signatures required: Adult patient (18 or over) and witness; parent (or guardian) and child plus witness if child is age 12–17; parent (or guardian) and witness if child is under age 12 or patient is adjudicated incompetent.

FOR OFFICE USE ONLY: We attempted to obtain written acknowledgment of receipt of our Notice of Private Practice, but Acknowledgment could not be obtained because: [ ] Individual refused to sign, [ ] Communication barriers prohibited obtaining the acknowledgment [ ] An emergency situation prevented us from obtaining acknowledgment [ ] Other (Please specify):

This authorization is valid for one year from the date signed.