



# Consent for Treatment & Payment

## **Consent to Treatment**

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I (name of person) \_\_\_\_\_, understand that psychotherapy treatment is a cooperative effort that involves open and honest communication between myself (client) and the therapist. Because difficult feelings and issues may need to be experienced and addressed, I understand there are certain risks associated with psychotherapy. These risks include, but are not limited to: worsening of mood, behavior and/or family functioning. I acknowledge that the benefits of treatment may not be immediately realized and understand that no guarantee or assurance is made as to the results that may be obtained. I hereby consent to treatment.

## **Release of Information/Assignment of Insurance Benefits**

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I understand that in the course of my treatment, it may be necessary for Positive Pathways to share my mental health information with other specialists, physicians, and/or health care agencies. Mental health information may also be shared with my insurance carrier in order for Positive Pathways to receive payment for services covered under my insurance plan. I assign to Positive Pathways all insurance benefits applicable and authorize my insurer or third-party payment program to render payment of such amounts directly to Positive Pathways. I understand that the therapists within Positive Pathways may consult with other therapists in order to enhance my treatment.

## **Billing Practices**

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I have been provided with a copy of Positive Pathways Policies and Fee Schedule and understand that should my account become delinquent, such outstanding balances may be sent to a collection agency and that I will be responsible for any fees by said collection agency. I also understand that Positive Pathways will charge me a \$40 late-cancellation fee if less than 24 hours notice of my inability to uphold my appointment is given, and an \$60 no-show fee if I fail to show up to my appointment without notice.

According to my benefit plan, I am responsible for:

- \_\_\_\_\_ co-payment, due at the time of service.
- \_\_\_\_\_ co-insurance, due at the time of service.
- \_\_\_\_\_ deductible, due at the time of service.
- I understand that my insurance company has a yearly limit of \_\_\_\_\_ sessions.

## **Notice of Privacy Practices**

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Positive Pathways, LLC is committed to the protection of your mental health information as required by federal and state law. Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

- **Duty to Warn and Protect**  
When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.
- **Abuse of Children and Vulnerable Adults**  
If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.
- **Prenatal Exposure to Controlled Substances**  
Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.
- **Minors/Guardianship**  
Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.
- **Insurance Providers** (when applicable)  
Insurance companies and other third-party payers are given information that they request regarding services to clients.

Information that may be requested includes, but is not limited to: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries.

I certify that I have read and fully understand the Consent for Treatment and Payment form, and agree to the Notice of Privacy Practices and the Policies & Fee Schedule.

Signature \_\_\_\_\_ Date \_\_\_\_\_



# Policies & Fee Schedule

Positive Pathways would like to thank you for trusting us with your care. We have made some changes in our policies and wanted to share them with you.

Our fees that are billed to insurance are as follows:

- Initial Assessment - \$185.00
- 45 minute Individual Session - \$125.00
- 45 minute Family Session - \$145.00
- Group Session - \$80.00

At times, the need arises for extended sessions. People often report significant benefit from sessions lasting 1 ½ hours. We are excited to offer these sessions as an added service to you. Insurance carriers often cover the first part of these sessions and the client is then responsible for the second half. The above rates apply for the out of pocket portion you are responsible for.

- No Show - \$60.00**
- Group No Show - \$40.00 or less, 48 hour notice is greatly appreciated)
- Late Cancellation - \$40.00 (24 hours or less, 48 hour notice is greatly appreciated)**
- Return Check Fee - \$30.00
- Phone calls lasting longer than 10 minutes are assessed at \$1.00 / minute
- Letter Writing - \$35.00 / page
- Disability Claims - \$30.00
- Copying Records - \$ 1.00 /page plus postage
- Half Day Court Attendance - \$500.00
- Full Day Court Attendance - \$1000.00

**We require payment at the time of service. If you have a deductible or co-pay, payment is expected at the time of service.**

**If you have insurance, please understand that this is an agreement between you and your insurance company. If your insurance requires an authorization for your visits, please make sure that you obtain this authorization before your first appointment. If your insurance company denies your visits for any reason, you will be responsible for the full fee of each of these visits. Please be aware that insurance benefits quoted by your insurance company are not a guarantee of payment and that you are ultimately responsible to know the benefits of your policy.**

If your insurance company requires a deductible, Positive Pathways will accept a payment of \$85 for the first session and \$65 for future sessions, until the deductible has been met. This payment is also due at the time of service. We would also ask you to please be aware of the status of your deductible.

I have read and understand the above statements and agree to be bound by the terms in this policy.

Signature \_\_\_\_\_ Date \_\_\_\_\_



# Patient Registration

## Patient Information

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Name \_\_\_\_\_

Address \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Work/Mobile Phone \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_

Marital Status \_\_\_\_\_ Gender  Male  Female

## Insured Information

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Patients relationship to insured  Self  Spouse  Child  Other: \_\_\_\_\_

If other than self, please complete:

Insured's Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Work/Mobile Phone \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_

Employer \_\_\_\_\_

## Insurance Policy Information

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Medicare  Medicaid  Champ US  Champ VA  Group Health Plan  Other

Insurance Company \_\_\_\_\_ Plan Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_

**Billing Information - (Complete only if you do not have insurance coverage)**

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Who is financially responsible for this patient?  Patient (Self)

Other (Please fill out the following)

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Work/Mobile Phone \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_

Employer \_\_\_\_\_

**Emergency Contact Information**

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Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone \_\_\_\_\_ Work/Mobile Phone \_\_\_\_\_

**How did you hear about us?**

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Website  Phone Book  Doctor: \_\_\_\_\_

Insurance Company  Brochure  Church: \_\_\_\_\_

Other: \_\_\_\_\_

**I have read the office information and policies and agree to these terms.**

Signature \_\_\_\_\_ Date \_\_\_\_\_



# Medical History

Medical Conditions (Headaches, stomachaches, thyroid, etc.) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name of Family Doctor \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Date of last physical \_\_\_\_\_

Have you ever been hospitalized for a medical condition?  Yes  No

Most recent hospitalization \_\_\_\_\_ Where? \_\_\_\_\_

Current Medications \_\_\_\_\_  
\_\_\_\_\_

Mental Health History (Depression, anxiety, etc.) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Previous Treatment?  Yes  No

Name of Psychiatrist \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Date of last visit \_\_\_\_\_

Have you ever been hospitalized for a mental health condition?  Yes  No

When? \_\_\_\_\_ Where? \_\_\_\_\_

Current Psychiatric Medications \_\_\_\_\_  
\_\_\_\_\_

## Sleep Habits

Number of Hours \_\_\_\_\_ How long have you been experiencing this? \_\_\_\_\_

Nightmares

Frequent waking

Early AM waking

Trouble falling asleep

Difficulty waking

Sleeping too much

Any difficulties with concentration?  Yes  No

Explain \_\_\_\_\_  
\_\_\_\_\_

Learning problems?  Yes  No

Explain \_\_\_\_\_  
\_\_\_\_\_

Highest Education Level Completed \_\_\_\_\_

Current School \_\_\_\_\_

GPA \_\_\_\_\_

Current Employment \_\_\_\_\_ How Long? \_\_\_\_\_

Satisfaction Level (1-10) \_\_\_\_\_

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_



# Coordination of Care Release

Communication between behavioral healthcare providers and your primary care physician (PCP), other behavioral health providers and/or facilities is important to ensure that you receive comprehensive and quality health care. This form will allow your behavioral health provider to share protected health information (PHI) with your other provider. This information will not be released without your signed authorization. This PHI may include diagnosis, treatment plan, progress, and medication, if necessary.

## Patient Rights

- You may end this authorization (permission to use or disclose information) any time by contacting the practitioner's office.
- If you make a request to end this authorization, it will not include information that may have already been used or disclosed based on your previous permission. For more information about this and other rights, please see the applicable Notice of Privacy Practices.
- You will not be required to sign this form as a condition of treatment, payment, enrollment or eligibility for benefits.
- You have a right to a copy of this signed authorization.
- If you choose not to agree with this request, your benefits or services will not be affected.

## Patient Authorization

I hereby authorize the name(s) or entities written below to release verbally or in writing information regarding any medical, mental health and/or alcohol/drug abuse diagnosis or treatment recommended or rendered to the following identified patient. I understand that these records are protected by Federal and state laws governing the confidentiality of mental health and substance abuse records, and cannot be disclosed without my consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time and must do so in writing. A request to revoke this authorization will not affect any actions taken before the provider receives the request. **This consent expires in six (6) months from the date of my signature below unless otherwise stated here.**

(Provider Name) \_\_\_\_\_ is authorized to release protected health information related to the evaluation and treatment of (Client Name) \_\_\_\_\_ (DOB) \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Primary Care Physician Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

## Disclosure may include the following written or verbal information (Check all that apply):

Diagnostic assessment     Treatment summary     Attendance and progress     Drug & alcohol assessment  
 Medical records     History intake     Diagnosis & treatment plan     Collaboration     Referral information

I hereby refuse to give authorization for any release of information (Please check this only if you refuse).

Signature (of Patient, Parent, or Guardian) \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_