



Informed Consent for Treatment

I give consent for evaluation and treatment to be provided for myself/my child by Dr. _____.

- I am aware that the practice of psychotherapy is not an exact science and that results cannot be guaranteed. No promises have been made to me about the results of treatment.
The risks, benefits, side effects and alternatives of treatment as well as the consequences of non-compliance with treatment have been discussed with me and I have had the opportunity to ask questions.
I understand that I need to provide accurate information about myself to my clinician so that I will receive effective treatment. I also agree to play an active role in my treatment process.
I understand that I may terminate treatment at any time.
I understand that what is discussed in therapy is confidential unless and until I (the client or parent) give consent to its release, with two exceptions. The therapist will need, and is compelled by law, to report to an appropriate other person(s) if:
1. The therapist believes that I am in danger of hurting myself or someone else, and
2. If there is reasonable suspicion that a child has been abused or neglected.

My signature below shows that I understand and agree with all of the above statements. I have had the opportunity to ask questions about the treatment process. If the client is a minor or has a legal guardian appointed by the court, the client's parent or legal guardian must sign this consent.

Signature of Patient or Parent/Guardian Date
Printed Name Relationship to Patient (if applicable)
Witness Signature Date

OFFICE INFORMATION:

Our office is a teaching facility and it is possible, at times, there will be an intern or other trainee sitting in on sessions. I understand this is a helpful part of my treatment and consent to this.

_____ I DO CONSENT _____ I DO NOT CONSENT

PRIVACY NOTICE

I have received the Kids, Inc. Health System Notice of Privacy Practices. My signature acknowledges I have received the Notice.

SIGNATURE: _____ DATE: _____

Kids Inc.

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Family Information

Client Name _____ M / F DOB _____ Age _____ Soc. Sec.# _____

Address _____ City _____ State _____ Zip Code _____

Home Phone _____ Cell _____ Work _____

School _____ Grade _____

Medications _____

Infectious Diseases _____ Allergies _____ Nicotine use _____

Father's name _____ Home Phone _____ Cell _____

Marital Status _____ Soc. Sec.# _____ DOB _____ Email _____

Address _____ City _____ State _____ Zip Code _____

Employer _____ Work phone _____

Medications _____

Mother's name _____ Home Phone _____ Cell _____

Marital Status _____ Soc. Sec.# _____ DOB _____ Email _____

Address _____ City _____ State _____ Zip Code _____

Employer _____ Work phone _____

Medications _____

Step Parent _____ Soc. Sec. # _____ DOB _____

Address _____ City _____ State _____ Zip Code _____

Employer _____ Work phone _____ Cell _____

Medications _____

1) **Sibling Name** _____ DOB _____ M / F AGE _____ Phone _____

Address _____ School _____ Grade _____

2) **Sibling Name** _____ DOB _____ M / F AGE _____ Phone _____

Address _____ School _____ Grade _____

3) **Sibling Name** _____ DOB _____ M / F AGE _____ Phone _____

Address _____ School _____ Grade _____

Emergency Contact: _____

Phone #: _____

Primary care physician: _____

Address: _____

Phone #: _____

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Financial Information

SELECTIVE THERAPY SERVICES: The intake session for Dr. Fine and Dr. Ryan is \$250.00. Each succeeding psychotherapy and/or pharmacological session is \$180.00. A brief psychotherapy and/or pharmacological session is \$100.00 - \$130.00. Other payment or fee arrangements must be worked out by the end of the first meeting.

INSURANCE INFORMATION / THIRD PARTY PAYMENT: We are licensed mental health providers so many insurance plans will help pay for therapy and other services we offer. You may obtain benefit information from the customer service number on your insurance card or from your agent. **Your insurance co-pay must be made at each visit.** There is a possibility that your health insurance plan will not cover outpatient mental health services. In either case, **the financial responsibility for services is yours as a client/parent.** Please note: Occasionally contact with collateral professionals, e.g., school counselors or teachers, may be needed and most insurance companies do not cover these expenses. This will require us to bill you directly.

THE KIDS INC. CANCELLATION POLICY requires that 24-hour notice be given if it is necessary to cancel or change an appointment. At the discretion of the doctor or therapist, the following charges may be applied: First late cancellation or failure to show – \$0 charge; 2nd late cancellation or failure to show – \$70; 3rd or more cancellations or failure to show – \$135 will be charged each time. I also understand that my insurance will not cover cancellation charges.

PATIENT/PARENT/GUARDIAN AGREEMENT:

Kids, Inc. has notified me that there is the possibility that outpatient mental health services may not be a covered benefit by my health insurance. **If my insurance is not in effect today or a service is not a covered benefit, I agree to be financially responsible for the charges that occur today and any subsequent charges that may occur.**

I give this office permission to release any information to my insurance company during treatment of me or my family, which is necessary to obtain authorizations or support any insurance claims on this account and secure timely payments due to the assignee or myself.

ASSIGNMENT OF BENEFITS:

I hereby assign medical benefits, including those from government-sponsored and other health plans to Kids, Inc. Medicare regulations may apply. A photocopy of this assignment is to be considered as good as the original. I agree to the above statements and attach my signature below.

Client's (or parent/guardian's signature)

Date

Printed name

PLEASE MAKE SURE WE HAVE A COPY OF YOUR INSURANCE CARD

Insurance Company _____

Cardholder name _____ Employer/Group Name _____

Effective Date of coverage _____ Family Coverage Yes No

Co-Pay per visit \$ _____ Deductible \$ _____ per person _____ per family _____

Is physician referral required? Yes No

Is authorization required? Yes No If yes, authorization #? _____ # of visits? _____

