

## Informed Consent for Treatment

I give consent for evaluation and treatment to be provided for myself/my child by  
(name of therapist) \_\_\_\_\_.

- 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: \_\_\_\_\_

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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 \_\_\_\_\_

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**Emergency Contact:** \_\_\_\_\_

Phone #: \_\_\_\_\_

**Primary care physician:** \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_

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## Financial Information

**REGULAR THERAPY SERVICES:** Our intake session is \$150.00. Each succeeding session is \$135.00. Any other payment or fee arrangement must be worked out before the end of the first meeting. Psychologists' fees are \$250.00 for the first session and \$150.00 for succeeding regular sessions.

**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 charge; 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. 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 (or parent/guardian signature) \_\_\_\_\_ Date \_\_\_\_\_

Printed name \_\_\_\_\_

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## **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? \_\_\_\_\_



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## Confidential Exchange Of Information with Primary Care Physician or other Behavioral Health Clinician/Facility

<b>Client/Patient</b>			
Name: _____ DOB: _____			
<b>Primary Care Physician or other Behavioral Health Clinician/Facility</b>			
Name: _____ Office or Facility: _____			
Phone: _____ Fax: _____			
Address: _____			
(Street)	(City)	(State)	(Zip)
<b>Consent to Release Information</b>			
Communication between behavioral health providers and your primary care physicians or other behavioral health providers is important to help ensure that you receive comprehensive and quality health care. This information will not be released without your consent. This information may include diagnosis, treatment plan, progress, and medication if necessary.			
I, Do _____/Do Not _____, authorize Kids Inc. to release information related to my evaluation and treatment to the physician/clinician named above. This consent will last one year from the date signed and I understand that I may revoke my consent at any time.			
_____	_____	_____	_____
Responsible Party's Signature	Printed Name of Signee	Relationship to Client	Date

Dear Dr. \_\_\_\_\_;

I'm writing to notify you that your above named patient was seen by me for a mental health evaluation and therapy. I look forward to working with you in the care of this client during their on-going therapy. Please let me know if you would like further information. I can be reached during my office hours or by confidential voicemail, if you prefer to leave a message.

Specific Information or Concerns:

Thank you for your assistance in coordinating care for this client.

Sincerely,

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Date Sent: \_\_\_\_\_

PLEASE DO NOT SEND MEDICAL RECORDS UNLESS SPECIFICALLY REQUESTED.

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## Credit Card Payment Policy

In an attempt to keep our clients' accounts up to date, we have implemented a very successful system of payment. By having your credit card information on file, we can efficiently update your account after each session.

In addition, 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 for an appointment – \$0 charge

2<sup>nd</sup> late cancellation or failure to show – \$70 will be charged

3<sup>rd</sup> or more cancellations or failure to show - \$135 will be charged each time

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I have been made aware of this policy and understand that my credit card may be charged for these fees. I also understand that my insurance will not cover cancellation charges.

I authorize Kids Inc. to charge this account for co-pays and cancellation fees as explained above.

### **Credit Card Information--**

Card Number \_\_\_\_\_

V/MC Expiration Date:(Mo./Yr.) \_\_\_\_\_ 3-digit CID \_\_\_\_\_

Name of Card holder: \_\_\_\_\_

Address of Card holder: \_\_\_\_\_

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Signature of Cardholder

Date

*If you have any question about this policy, please discuss it with your therapist.*