**Informed Consent for Treatment**

**PROVIDER-CLIENT SERVICE AGREEMENT**

Welcome to our Practice, MENTUS Behavioral Health. This document/agreement contains important information about our Practice’s professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights pertaining to the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment,payment/reimbursement, and health care operations. Although this document may seem voluminous or complex, it is important that you understand the terms contained herein Upon signing this consent document, it will also represent an agreement between us – the patient/client and your mental health provider. Of course, we can discuss any questions you may have prior to signing this document /agreement or at any time in the future.

**PSYCHOTHERAPY SERVICES**

Therapy is a relationship that works in part because of clearly defined rights and responsibilities held by each person involved. As the patient/client, you have certain rights and responsibilities that are important for you to understand. There are also legal limitations to those rights that you should be aware of. MENTUS Behavioral Healthas your mental health provider, has corresponding responsibilities to you. These rights and responsibilities are described in the following sections.

Psychotherapy has both benefits and risks. Risks may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness, and helplessness, because the process of psychotherapy often requires discussing the unpleasant aspects of your life. However, psychotherapy has been clearly shown to benefit individuals who undertake it. Therapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness, and insight; as well as increased skills for managing stress and resolutions to specific problems. However, there are no guarantees regarding specific results. Psychotherapy requires a very active effort on your part. To be clear, , you will have to work on matters discussed outside of therapy sessions in order for stated sessions to be most successful.

The first two to four (2-4) sessions will involve a comprehensive evaluation of your needs. By the end of the evaluation, we will be able to offer you some initial impressions of what our work might include. At that point, we will discuss your treatment goals and create an initial treatment plan. You should evaluate this information and make your own assessment about whether you feel comfortable working with your mental health provider. If you have questions about our procedures, we should discuss them as soon as they arise. If for some reason your doubts persist, we will be happy to help you set up a meeting with a different mental health professional for a second opinion.

**PSYCHIATRIC SERVICES**

Medications may be indicated when your mental health symptoms are not responsive to psychotherapy alone. When a mental illness markedly impacts your ability to work, maintain interpersonal relationships, and/or properly care for your basic needs, medication may offer much-needed relief. If it is agreed that medications are indicated, we will discuss all of the medication options that are available to treat your current condition(s). We, the Practice, will present the necessary information in a language that you can easily understand to better enable you to make the best decision possible for you. You will learn how the medication(s) work(s), dosage, frequency, expected benefits, possible side effects, drug interactions, and any withdrawal effects that you may experience if you stop taking the medication(s) abruptly. By the end of the discussion, you will have all the information necessary to enable you to make an educated and rational decision as to which medication(s) is/are right for you.

You may already be receiving psychotherapy from another therapist / mental health provider, and are being referred to us for purposes of medication management. In this case, we will make a strong and dedicated effort to coordinate your ongoing care with your referring therapist andi your consent. We believe communication between mental health professionals is key to providing effective care. Psychotherapy is a mandated part of treatment at MENTUS Behavioral Health. As such,non-compliance with this mandate may be subject to termination of services.

Please note that not everyone is a good candidate for medication therapy. Such therapy requires strict adherence to dosage and frequency, close follow-up, and occasional regular blood testing. Your ability to adhere to your prescribed medication treatment will be taken into consideration in making your decision to start such therapy. We also support a bio-psycho-social model of medical treatment. Treatment that considers your biological status, genetics, psychological development, and social issues together will yield the best chance for success in achieving your mental health goals.

**APPOINTMENTS**

The time scheduled for your appointment is assigned to you, and you alone. Reminder calls, text messages, and emails are a courtesy provided by the Practice. However, you are ultimately responsible for remembering your appointment date and time, and attending same as scheduled. Arriving at appointments on time is expected. An initial 5-minute grace period for psychiatric follow-up appointments and an initial15-minute grace period for counseling appointments are courteously provided to you. Notwithstanding same,you will subsequently be considered a “late cancel/NO SHOW” and will be rescheduled for the next earliest available appointment

**Psychotherapy**: Appointments will ordinarily be 45-50 minutes in duration, once per week, at a time we agree upon, although the frequency of some sessions may fluctuate according to client/patient needs.

**Medication**: At your initial 50-minute visit, we will decide, together, the structure of your therapy. If medications are prescribed, or changed, we prefer to conduct a 20-minute follow-up visit in 1-2 weeks. This is deemed necessary to ensure proper medication administration and minimize any side-effects you may experience. If your symptoms improve, your follow-up visits can be modified to occur at monthly intervals. For patient/clients on maintenance therapy, follow-up visits can be held at 3-month intervals. We may discuss an alternate treatment structure depending on your particular circumstances.

**PROFESSIONAL FEES**

You are responsible for making payment to MENTUS Behavioral Health at the time of your session for the services provided, unless prior arrangements have been made. Payment must be made by check, cash, or credit card (most major credit cards accepted). Please note that any checks returned to our office due to insufficient funds or any other issues related to the client’s/patient’s banking institution are subject to an additional fee of up to $25.00 to cover any bank-imposed fee(s) that may be incurred by the Practice. If you refuse to pay your debt resulting from the services provided by MENTUS Behavioral Health, the Practice reserves the right to use an attorney or collection agency to secure overdue payment(s). Any outstanding balance must be paid, or a payment arrangement set, in order to continue providing services to its clients/patients.

**CANCELLATION/ NO SHOW POLICY**

If you need to cancel or reschedule a session, we ask that you provide me the Practice with 24-hour notice. If you miss a session without canceling your scheduled appointment or cancel your appointment with less than 24-hour notice, our policy is to collect a fee of $50.00 for psychotherapy and $275.00 for psychiatric services. It is important to note that insurance companies do not provide reimbursement for canceled sessions; thus, you, the client/patient, will be responsible for the fee(s) as described above. If it is possible, the Practice will try to find another time to reschedule the missed / untimely canceled appointment.

**If you miss three (3) appointments, you are subject to discharge from treatment due to inconsistent attendance. You will be eligible to re-apply for services in three (3) months from the date of discharge.**

**INSURANCE**

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. With your permission, our billing service and the Practice will assist you to the extent possible in filing insurance claims and ascertaining information about your health insurance coverage, but you are responsible for knowing your coverage and for letting us know if/when your coverage may change.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. Managed Health Care plans, such as HMOs and PPOs, often require an advance authorization, without which they may refuse to provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person’s usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While several goals may be accomplished in short-term therapy, some patients/clients feel that they require more services after their respective insurance benefits become unavailable. Some managed-care plans will not allow the Practice to provide services to you once your benefits end. If this is the case, the Practice will do its best to find another mental health provider to help you continue your treatment.

You should also be aware that most insurance companies require you to authorize the Practice to provide them with a clinical diagnosis. (“Diagnoses” are technical terms that describe the nature of your problems and whether they are short-term or long-term in nature. All diagnoses come from a book entitled the “DSM-5.” There is a copy of the DSM-5 book in our Practice and we will be glad to let you review it to learn more about your diagnosis, if applicable.). Sometimes to the Practice may have to provide additional clinical information, such as treatment plans or summaries, or (in rare cases) copies of the entire medical record. This information will become part of the insurance company files and will probably be electronically stored.. Though all insurance companies claim to keep such information confidential, MENTUS Behavioral Health has no control over what the insurance companies do with stated information/documentation once it is in their possession. In some cases, the health insurance companies may share the information with a national medical information databank. The Practice will provide you with a copy of any report submitted by the Practice if the client/patient requests same. By signing this document / consent form, you agree that MENTUS Behavioral Health can provide the requested information to your health insurance carrier if you plan to pay utilizing your health insurance coverage.

In addition, if you plan to use your insurance, authorization from the insurance company may be required before it will cover therapy fees. If you did not obtain authorization and it is required by your health insurer, you may be responsible for full payment of the full fee for services provided to you by the Practice. Many health insurance policies leave a percentage of the fee (which is called co-insurance) or a flat-dollar amount (referred to as a co-payment) to be covered by the patient. Either amount is to be paid at the time of the visit by check, cash, or credit card. In addition, some health insurance companies also have a deductible, which is an out-of-pocket amount, that must be paid by the patient before the insurance companies are willing to begin paying any amount for services provided by the Practice. This will typically mean that you will be responsible to pay for initial sessions provided by MENTUS Behavioral Health until your deductible has been met; the deductible amount may also need to be met at the start of each calendar year. Once of the Practice receives all related information about your insurance coverage, we will discuss what we can reasonably expect to accomplish with the benefits that are available and what will happen if coverage ends before you feel ready to end your sessions. It is important to remember that you always have the right to pay for MENTUS Behavioral Health’s services yourself in order to avoid the problems described above unless prohibited by the pertinent provider contract.

If MENTUS Behavioral Health is not a participating provider under your insurance plan, the Practice will supply you with a receipt of payment for services, which you can submit directly to your insurance company for reimbursement. Please note that not all insurance companies reimburse their insureds for out-of-network providers. If you prefer to use a participating provider, the Practice will refer you to a colleague.

**PROFESSIONAL RECORDS**

The Practice is required to keep appropriate records of the psychological services that we provide to our clients/patients. Your records are maintained in a secure location in the office. The Practice keeps brief records noting that you attended your appointment, your reasons for seeking therapy, the goals and progress set for treatment, your diagnosis, topics discussed, your medical, social, and treatment history, records received from other medical providers, copies of records we send to other providers and/or insurer, and your billing records. Except in unusual circumstances that involve potential danger to yourself, you have the right to a copy of your file. Because these are professional records, they may be misinterpreted and/or upsetting to untrained readers. For this reason, we recommend that you initially review them with your mental health provider, or have them forwarded to another mental health professional to discuss the contents thereof. If the Practice refuses your request for access to your medical/billing records, you have a right to have the Practice’s decision reviewed by another mental health professional, which we will discuss with you upon your request. You also have the right to request that a copy of your file be made available to any other health care provider at your written request.

**CONFIDENTIALITY**

Policies about confidentiality and other information about your privacy rights, are fully described in a separate document entitled "Notice of Privacy Practices." You have been provided with a copy of that document, and we have discussed the issues contained therein. Please remember that you may reopen the conversation at any time that you remain a client/patient of MENTUS Behavioral Health.

**PARENTS & MINORS**

While privacy in therapy is crucial to successful progress, parental involvement can also be essential. It is the Practice’s policy not to provide treatment to a child under the age of 13 unless he/she agrees that the Practice can share whatever information is considered necessary with a parent. For children ages 14 and/or older, the Practice requests an agreement between the client/patient and the parents of stated client/patient allowing the Practice to share general information about treatment progress and attendance, as well as a treatment summary upon completion of therapy. All other communication will require the child’s/minor’s agreement unless the Practice feels there is a safety concern (see also above section on Confidentiality for exceptions), in which case the Practice will make every effort to notify the child/minor client/patient of its intention to disclose information ahead of time and make every effort to handle any objections that may arise.

**CONTACTING THE PRACTICE**

We are often not immediately available by telephone. We do not answer our phone when we are with clients/patients or are otherwise unavailable. At these times, you may leave a message on our confidential voicemail and your call will be returned as soon as possible, but it may take one to two days to return the patient/client’s call pertaining to non-urgent matters. If, for any number of unseen reasons, you do not hear from the Practice or we are unable to reach you, and you feel you cannot wait for a return call; or if you feel unable to keep yourself safe, please contact your provider via the patient portal application or, if it is afterhours, immediately go to your Local Hospital Emergency Room, or call 911. The Practice will make every attempt to inform you in advance of planned absences.

**OTHER RIGHTS**

If you are unhappy with what is happening with your treatment, the Practice hopes you will speak with us so that we can respond to your concerns. Such comments will be taken seriously and handled with the upmost care and respect. You may also request that we refer you to another provider, and you are free to end treatment at any time. You have the right to considerate, safe, and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment. You have the right to ask questions about any aspects of therapy and about our specific training and experience. You have the right to expect that we will not have social or sexual relationships with clients or with former clients.

**EXPECTED BEHAVIOR**

**Verbal or Physical aggression cannot be tolerated and will be grounds for immediate discharge from treatment.**

**Our property is a non-smoking campus, smoking on the premises will be grounds for immediate discharge from treatment.**

**CONSENT TO PSYCHOTHERAPY AND/OR PSYCHIATRIC SERVICES**

Your signature below indicates that you have read this Agreement and the "Notice of Privacy Practices" and agree to their terms.

**FOR A MINOR BOTH PARENTS OR GUARDIANS MUST SIGN**

Patient’s Signature Date

Parent or Guardian Signature Date

(for children under 18)

Print name Date

**P R E L I M I N A R Y I N T A K E I N F O R M A T I O N**

PATIENT LEGAL NAME SEX DATE

PREFERRED NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RACE

HOME PHONE ( ) CELL PHONE ( )

DATE OF BIRTH AGE SSN

EMAIL ADDRESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MARITAL STATUS: ( )MARRIED ( )SINGLE ( )DIVORCED ( )WIDOWED ( )MINOR ( )OTHER

(FOR MINORS) NAME OF PARENT/GUARDIAN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MAILING ADDRESS

CITY/STATE ZIP

NAME OF PRIMARY CARE PHYSICIAN

WHO REFERRED YOU TO OUR PRACTICE?

PERSON TO NOTIFY IN CASE OF EMERGENCY

PHONE (\_\_\_\_) RELATIONSHIP

**FOR INSURANCE PURPOSES:**  POLICY ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

INSURANCE POLICYHOLDER NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB OF POLICYHOLDER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_EMPLOYER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PLEASE PROVIDE AN INSURANCE CARD AND PHOTO ID AT THE TIME OF CHECK IN AT EACH VISIT!**

**PLEASE READ.**

**FEES FOR NO-SHOWS OR UNCANCELLED VISITS**: I understand that I will be charged for each missed or uncancelled scheduled appointment if I do not give one full business day’s notice (24 hours) of the cancellation. Monday appointments must be cancelled by Friday of the previous week. These charges will not be billed to my insurance company; rather, I will be personally held responsible for same. New patient missed appointment fees are $100. 00. Existing therapy patients will be charged $75.00 for subsequent occurrences.

**COORDINATION OF CARE:** I understand that in the case that I see more than one provider in this office as part of my care, I will give permission to those providers to discuss my case for purposes of referral, coordination of services, and crisis/on-call services for as long as I am a client/patient of MENTUS Behavioral Health. By initialing above and by signing below, I acknowledge that I have read, understood, and accepted these terms of my financial responsibility. I understand that this agreement applies to each doctor/patient and/or provider/client relationship into which I enter today or in the future.

**FOR A MINOR BOTH PARENTS OR GUARDIANS MUST SIGN**

Patient’s Signature Date

Parent or Guardian Signature Date

(for children under 18)

Print name Date

**PERMISSION TO OBTAIN/RELEASE RECORDS**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (patient name), \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (patient's DOB), give my permission for

MENTUS Behavioral Health to □ release □ obtain my medical records to/from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(doctor/hospital/clinic/individual) so they can better understand my condition

Tel.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fax.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PERMISSION TO OBTAIN/RELEASE SENSITIVE INFORMATION:

By putting my initials by each item below, I understand that I give permission for records to be sent/obtained that may contain information about:

 \_\_\_\_\_\_\_\_\_\_\_ my mental health,

 \_\_\_\_\_\_\_\_\_\_\_ any transmittable diseases I may have (such as HIV/AIDS, Tuberculosis, or MRSA)

 \_\_\_\_\_\_\_\_\_\_\_ genetic records, and/or

 \_\_\_\_\_\_\_\_\_\_\_ drug and alcohol records.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I UNDERSTAND THAT:

I do not have to give my permission to share these records.

If I want to revoke this permission, I need to talk to my doctor or a staff person and provide written documentation of my decision

This form is only good for the time client/patient is being treated by MENTUS Behavioral Health.

**FOR A MINOR BOTH PARENTS OR GUARDIANS MUST SIGN**

Patient’s Signature Date

Parent or Guardian Signature Date

(for children under 18)

Print name Date