

Informed Consent for Treatment

I have chosen to receive psychotherapy services from _____. My choice to participate in therapy has been voluntary and I understand that I may terminate therapy at any time. I understand that I am being treated only by _____, and that other therapists present at the offices of Behavioral Health Associates of Charlotte are not participating in my treatment, nor are they responsible for my care.

I understand that I need to attend all scheduled appointments. If I am unable to attend a scheduled appointment I understand that I must let my therapist know at least 24 hours in advance by leaving a voice- mail at 704-365-6260, otherwise I will be responsible for my full fee. I further understand that if I am more than 20 minutes late for my scheduled appointment without notice, my therapist reserves the right to cancel my appointment and I will be responsible for my full fee.

I understand that therapy is a cooperative effort between the client and the therapist, and there is no assurance that I will feel better. I agree to work with my therapist in a cooperative manner to resolve difficulties. I understand that during the course of psychotherapy material may be discussed which will be upsetting in nature and that this may be necessary to help the client resolve his or her problems. If I have any questions or concerns about my treatment I agree to discuss them with my therapist.

I understand that confidentiality of records of information collected about the client will be held or released in accordance with state laws regarding confidentiality and according to the Federal Health Insurance Portability and Accountability Act of 1996 (a copy of which as it pertains to this practice is available to me if I ask for it). In general, this means that information collected during therapy will be released only with my written consent, except where permitted or required under state law. I further understand that, under state law, confidential information may be released without my consent in conditions including, but not limited to:

- My therapist has reason to believe that a child or dependent person is in danger
- There is imminent danger of a specific person harming him or herself or some specific other person
- My therapist is ordered to release information by a court of competent jurisdiction

I understand that if therapy is being paid for using insurance, my therapist will release any and all records pertaining to treatment to the insurance company and to the primary care physician electronically or by mail if such disclosure is necessary for claims processing, case management, coordination of treatment, or utilization review purposes. I authorize insurance to pay _____.

I understand that I am responsible for any fee or co-pay at the time of service. I understand that if I fail to pay my full balance for more than two appointments, I will no longer be eligible for services until my bill is paid in full. I understand that it is my responsibility to determine that insurance will pay for services before they are rendered, and that if they do not, I will be financially responsible for all services rendered. I also understand that any check returned by my bank will cause a \$25 returned check fee to be added to my account. If it becomes necessary to use collection processes due to lack of payment for services, my therapist will disclose as little confidential information as necessary for the purposes of collection.

I understand that I may address any concerns or grievances with my therapist or any other representative of my insurance company at any time. I may also file a grievance with my therapist's licensing board.

I attest that if the client is a minor or is otherwise dependent on me, I am the natural parent or legal guardian of the client, and therefore, am authorized to make this request for and give my consent to the treatment and services mentioned on this form.

I understand that I can revoke this consent at any time, except to the extent that treatment has already been rendered or that action has been taken in reliance on this consent and that if I do not revoke this consent, it will expire automatically one year after all claims for treatment have been paid as provided in any benefit plan.

Patient's signature

Date

Parent/ Guardian's Signature

Witness's signature