

INFORMED CONSENT

Thank you for choosing to see one of our Licensed Clinical Professional Counselors. Today's appointment will take approximately 45 – 50 minutes. We realize that starting counseling is a major decision and you may have many questions. This document is intended to inform you of our policies, State and Federal Laws and your rights. If you have other questions or concerns, please ask and we will try our best to give you all the information you need

CONFIDENTIALITY AND EMERGENCY SITUATIONS: Your verbal communication and clinical records are strictly confidential except for: a) information shared with our staff psychiatrist, b) information (diagnosis and dates of service) shared with your insurance company to process your claims, c) information you and/or you child or children report about physical or sexual abuse; then, by Illinois State Law, I am obligated to report this to the Department of Children and Family Services, d) where you sign a release of information to have specific information shared and e) if you provide information that informs me that you are in danger of harming yourself or others f) information necessary for case supervision or consultation and h) or when required by law. If an emergency situation for which the client or their guardian feels immediate attention is necessary and I am unavailable, the client or guardian understands that they are to contact the emergency services in the community (911) for those services. Your provider will follow those emergency services with standard counseling and support to the client or the client's family.

Signature(s) _____ **Date:** _____

FINANCIAL/INSURANCE ISSUES: As a courtesy we will bill your insurance company for you if you wish. We ask that at each session you pay your co-pay or 50% of the fee. In the event you have not met your deductible, the full fee is due at each session until the deductible is satisfied. If your insurance company denies payment or does not cover counseling, you authorize First Health Associates, to collect the amount due on the credit card provided at your initial visit and request a receipt to be sent to the address on file. After 60 days any unpaid balance will be charged to the credit card on file and if and when payment is received by your insurance company a full refund will be issued immediately. In the event that an account is overdue and turned over to our collection agency, the client or responsible party will be held responsible for any collection fee charged to our office to collect the debt owed. We ask that every client authorize payment of medical benefits directly to First Health Associates, SC.

- First Health Associates does not send monthly statements. You will be asked to sign a credit card authorization form at your initial visit. If your credit card is used to collect a balance, a letter & receipt of payment will be mailed to the address on file

Lastly, if you need to cancel or reschedule an appointment, please give 24 business hours advance notice, otherwise you will be billed at the hourly rate. We sincerely appreciate

your cooperation and at any time you have any questions regarding insurance, fees, balances or payments please feel free to ask. **You may have a copy of this form if requested.**

Signature(s) _____ Date _____

NOTICE OF PRIVACY PRACTICES AND CLIENT RIGHTS: *I/We have read and received a copy of the, Notice of Privacy Practices and Client Rights document.*

*May we contact you at home (circle one) **yes no?** May we contact you at work **yes no?***

*May we contact you by cell phone **yes no?** Where may we contact you _____
_____?*

Signature(s) _____ Date _____

COORDINATION OF TREATMENT: It is important that all health care providers work together. As such, we would like your permission to communicate with your primary care physician and/or psychiatrist. Your consent is valid for one year. **Please understand that you have the right to revoke this authorization, in writing, at any time by sending notice. However, a revocation is not valid to the extent that we have acted in reliance on such authorization.** If you prefer to decline consent no inform will be shared.

____ You may inform my physician(s) ____ I decline to inform my physician

PHYSICIAN NAME: _____

CLINIC: _____

ADDRESS: _____

PHONE: _____

Signature(s) _____ Date _____

CONSENT FOR TREATMENT OF CHILDREN OR ADOLESCENTS: I/We consent that _____ maybe treated as a client at First Health Associates, SC . At times it maybe necessary to schedule appointments during school hours. We ask for your cooperation to provide the most timely treatment for you and your children.

Signature(s) _____ Date _____