Sullivan Mental Health Services, LLC

Consent for treatment

(Please initial in the spaces provided and sign the bottom)

Fees, Payment, and Insurance Billing

_____ I agree to make payment at the time of service. I agree to pay my known copay, the percentage that my insurance does not pay, or the full fee at the time of my visit.

_____ I understand that appointments not cancelled 24 hours in advance will result in a charge. This fee is $25 for counseling sessions. As a courtesy Sullivan Mental Health Services will try to provide reminder calls, however, this is not a guarantee. Clients may not dispute a no show fee for not receiving a reminder call.

_____ Additional fees may be billed for services such as phone calls of more than 10 minutes in length, written reports or letters and other professional services.

_____Any account that has had no payment activity for 90 days will qualify for submittal to a collection agency or small claims court. Sullivan Mental Health Services, LLC does not extend credit. An annual rate of 21% will be applied to the full balance if payments are not made as agreed. In the event the client defaults on this agreement, Client understands a fee equaling 30% of the overdue balance will be added to your account to cover collection costs. Necessary protected health information may be released to collection agencies for collection efforts.

Consent for treatment

_____ I have been fully informed of my rights as a client of this agency. We will provide our professional services; however, there is no guarantee that you or your family members will benefit from services. With that knowledge, I request and consent to receive therapy from qualified personnel of this agency.

_____I understand that my therapist may work with me at this agency, in my home, or in other settings based on his/her professional judgment. I agree to participate actively in my therapy, to cooperate with my therapist, and to complete required homework assignments or other activities included in my therapy.

Privacy Practices

_____ Sullivan Mental Health Services is required by law to maintain the privacy of protected health information, and must inform you of our privacy practices. You have a right to request a paper copy of this notice. The staff of this agency may not disclose information about treatment to anyone outside this agency without written consent, except as required by law to comply with a court order, to prevent suicide/self-harm or harm to others, or to stop or prevent abuse of a child, senior, or disabled person. Participation in treatment may require written consent to allow staff of this agency to provide some information about treatment to a referring agency, if this is the case, the form provided for my written consent for this disclosure will state what specific types of information will be disclosed. I understand that confidentiality extends to other clients in the treatment setting. I understand I cannot discuss with those outside of my treatment setting any identifying information of those I meet, see, and hear about during my treatment stay including names, physical descriptions, or stories which may be common knowledge to those outside of the treatment thereby identifying the individual being discussed. I understand my confidentiality is protected by law and understand the exceptions to the requirement of confidentiality.

Consent for treatment of Minor Patients

_____As a parent or legal guardian obtaining services for a minor child I agree that it is my responsibly to pay for any services provided. If another party is required to pay a portion of these expenses it is my responsibility to collect from the other party. I certify that I am the legal guardian and I have legal right to approve treatment. I hereby give my consent for the treatment of the child, ____with a DOB:_____/_____/_____.

____

Responsible Party Signature Date

Staff Signature: ____ Date: ______________________