**CONSENT TO SERVICES**

**Treatment Information**

Welcome, this form is designed to help you feel more comfortable with the therapeutic process and to explain certain policies and procedures followed by the clinicians of Whole Living LLC. Treatment is a team approach at Lokahi, meaning Dr. Merritt will recommend empirically validated therapies that are best suited for your care, and together you and she will develop a treatment plan that fits your lifestyle. This collaborative approach provides you with choices and treatment options that encourage you to become an active participant in your treatment and to develop a long-term method of working through life. Likewise, frequent collaboration between Dr. Merritt will inform yours or your child’s treatment.

Treatment length, frequency, and intensity is dependent your personal needs. Typically, fifty-minute individual sessions occur weekly or bi-monthly. If you are unable to keep an appointment, please provide 48 hours’ notice to avoid a session charge. In cases of repetitive cancellations within 48 hours, a full fee for service will be charged without prior communication with you. If you need to contact Dr. Merritt between sessions, please do so by calling or texting Whole Living LLC at 972.512.8234 or via email at [YourWholeLiving@gmail.com](mailto:YourWholeLiving@gmail.com), please allow 72 hours for response. Consider that we do not disseminate HIPAA protected information via cell texting or email. We cannot store your information in that milieu. Understand that your choice to provide information via those sources are not considered HIPAA compliant. Charges for communications are listed in the fee schedule.

**If you have an emergency, please call 911 or go to the nearest emergency room.**

**Psychiatric consults and medication**

Whole Living, LLC does not retain a psychiatrist on staff, nor do we prescribe or dispense psychiatric medication. Whole Living, LLC can provide you with a psychiatric referral if deemed necessary. We encourage you to sign a release to enable Whole Living practitioners to consult with your or your child’s Psychiatrist or Nurse Practitioner.

**Clinician’s Information**

Dr. Merritt is a Doctor of Clinical Psychology (PhD) and the staff at Whole Living LLC are dedicated to the future advancement of education, research, and clinical application of the fields of psychology, nutrition, and health and wellness. Dr. Merritt adheres to all laws set forth by the state of Texas as well as the practice rules of the State Board of Texas Examiners of Psychologists. Dr. Merritt is a post doctorate fellow and her Supervisor is Nicole F. Keehn, RN, MS (N), PsyD at 972.975.2007, email Lokahilifecenter@gmail.com.

**Confidentiality**

It is your right that information discussed during sessions will be kept private and confidential. However, there are conditions in which confidentiality may be violated. These include evidence of abuse of a minor, elder, or mentally impaired individual.

1. Evidence of imminent suicidal or homicidal intent.
2. You are a client referred by the court or an agency.
3. Your records have been subpoenaed by a court of law.
4. Your health insurance company (payer source) requires certain patient information as dictated by law.
5. Certain patient information may be submitted to a collection agency in order to collect the balance of an overdue account.
6. Persons designate as emergency contact may be contacted without your prior notification if there is indication or concern that you or your child is at risk.
7. Whole Living, LLC professional staff have a legal responsibility to disclose client information without prior consent when a client is likely to harm himself, herself or others unless protective measures are taken, when there is reasonable suspicion of abuse of children, dependent adults or the elderly, when the client lacks the capacity to care for him or herself or when there is a valid court order for the disclosure of client files. Fortunately, these situations are infrequent.

**Child Specific Considerations**

I understand that if my child has parents that are divorced and/or part of a joint custody arrangement I must furnish the clinician with a copy of the divorce decree and most current child custody arrangement and/or provide any updates and changes before work can begin per Texas state law.

Your child may be asked to sign an assent to therapy. Assent indicates that the child or adolescent agrees to terms of treatment and understands limits of confidentiality regarding information they might share with their practitioner.

If you are suing someone or being sued, or if you are charged with a crime and you tell the court that your child is a client at Whole Living, LLC, Whole living or your child’s therapist may then be ordered to show the court your child’s records. Please note, as of 2015 in the state of Texas, psychologists (and any clinician in training) are not permitted to provide statements in court regarding appropriate custody of a minor, parental fitness (i.e. which parent is a psychologically better fit to raise the child), and/ or parental alienation unless they have had specialized training in this area (usually referred to as practitioners who achieved Forensic education and/ or training) and/ or have conducted a child custody evaluation. Please consult with your clinician regarding their training in this area and with your lawyer should you believe these issues may arise. Please consult with your child’s therapist if you have any questions about confidentiality.

**Treatment Risks/ Benefits**

Psychological treatment involves reassessing and reframing personal past history and personal future approaches to life. The new coping and self-assessment strategies a person learns may lead to their restructuring perceptions of family process and they may alter the way they interact with family members and others. Changes in thought process and behavior can initially be unsettling to the individual, family, and significant others. During the course of therapy people often discuss difficult topics that may lead to their initially feeling worse before they feel better.

**Patient Record/ Document Information**

It is required by federal and state governments that therapy notes and psychological batteries be maintained for several years. The information contained in said documents is considered privileged unless subpoenaed by a court of law. If you use insurance to pay for treatment, some insurance companies require copies of notes. This will be discussed prior to your initial session and you will have the opportunity to ask any questions you may have. Please notify us prior to your session start if you require FMLA, Disability, SS, letters, summaries, or other paperwork.

**Authorization to Release and Obtain Medical Records**

Authorization is intact for 2 years to date of release.

Emergency Contact:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relation to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City/State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Release and obtain complete health care information and records.
* Release and obtain only information necessary for treatment. Specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other (ex. medical doctor, caregiver, therapist, nurse, etc.):

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relation to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City/State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email/ Fax \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Release and obtain complete health care information and records.
* Release and obtain only information necessary for treatment. Specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Permission to Record Sessions**

I give clinicians at Whole Living LLC permission to audio and or video record assessment and therapy sessions. Recordings may be conducted at the discretion of our practitioners as a requirement for forensic evaluation or in cases where a recording may provide a deeper understanding of the therapeutic process for patients or their families. All audio/ video will be stored in hard copy, electronic media storage device, or secure and restricted internet webpages. The recorded material will be maintained under the Federal HIPAA guidelines (to include password protection, double lock file, and de-identification when indicated).

Signature (patient/authorized representative) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Consent to Payment of Fees for Services Rendered**

Verification or confirmation of insurance benefits does not guarantee services will be covered. In the event your private insurance does not cover a service, payment of the balance will be the responsibility of the insured or insured’s representative, parent, or guardian if he/she is under the age of 18 years of age. Please speak with an office manager at the onset of treatment for an estimation of costs for services, including psychological or neuropsychological testing. Payments are due on the day services are rendered.

* **Consent to Bill Insurance and Assignment of Benefits**

I request that payment of authorized private insurance benefits be made to either me or on my behalf for any services being furnished to me by Suzan Merritt, PhD or her supervisor, Dr. Nicole Keehn, PsyD of Lokahi Life Center, PLLC. I authorize any holder of medical information about me to release any information needed to determine these benefits or the benefits payable for related services.

* **Consent to Out of Network/ Out of Pocket Payments**

I understand I am being provided services and am responsible for payment at the time of service. My insurance will not be billed/I have no insurance coverage.

|  |  |
| --- | --- |
| ***Service*** | ***Fee*** |
| Diagnostic and Evaluation Session (Initial Visit) | 200.00 |
| Regular Office Visit (53 minutes) | 150.00- 200.00 |
| Family or Couples Sessions (53 minutes) | 150.00- 200.00 |
| Child Therapy Individual Session | 150.00-200.00 |
| Double Sessions (1 hour and 45 minutes) | 250.00 |
| Crisis, Custody, Forensic, and special circumstance sessions | Charges will reflect market valuation and are at the discretion of the practitioner. |
| Cancellation Policy | 45.00 if appointment not cancelled within 48 hours. In repeat cancellation circumstances the full session fee will be applied. |
| Psychological/Neuropsychological/Academic/ Forensic Assessment | 500.00 -5,000.00 |
| Assessment Feedback Session | 150.00 |
| EMDR (1 hour and 15 minutes) | 175.00 |
| Court Appearances (must be scheduled two weeks in advance) | $300.00/ hour; minimum 3 hours  $200.00 (for document preparation only) |
| Written Reports | Assessment reports included in assessment fee |
| Medical Record Request | 30.00 – 50.00 (document request over 25 pages may incur additional fees) |
| Letters/ FMLA/ Disability/ SS/ Other | 100.00 – 150.00/ documents or by page |
| Document Review | 150.00/ hr. |
| Phone collaboration with attorneys, guardians, ARD meeting phone collaboration, or other practitioners | 150.00/ 45 minutes |
| School Visits | 250.00 |
| Returned Check fee (per check) | 25.00 |
| Foster/ Orphan/ Telos (sliding scale for persons who qualify) | Four session initial limit short-term therapy (will re-evaluate for continued treatment on case by case basis) |
| First Responders/ Medical Doctors/ Military/ Nurses/ Respiratory Therapists (sliding scale for persons who qualify) | Six session initial limit short-term therapy (will re-evaluate for continued treatment on case by case basis) |
| Email responses/ Family Wizard Post (If more than 1 per child therapy session update per week) | 100.00 |

***By signing below, you agree to the terms above and responsibility for outstanding balances***.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

Signature of patient or authorized representative Relationship Date

**Credit Card Authorization Form**

All patients are required to submit credit card information and maintain up-to-date credit card information on file.

PLEASE PRINT OUT AND COMPLETE THIS AUTHORIZATION AND RETURN TO US. All information will remain confidential.

Client Name if different from cardholder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Card Holder Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Billing Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Credit Card Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Expiration Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Security Code (3-digit): \_\_\_\_\_\_\_\_

I authorize Whole Living LLC to charge the agreed amount for copay, deductible to meet session costs, fees for appointments not cancelled within 48 hours, repetitive failure to cancel as per policy fees (whole session cost), and any and all other required by your insurance, legal entity, and/ or any fees listed in the above schedule or quoted to you by a representative of Lokahi or Dr. Merritt.

I agree that I will pay for this service in accordance with the issuing bank cardholder agreement.

Cardholder- Print Name, Sign and Date Below:

Printed Name on Card: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_

Signature of Card Holder \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Consent to Services**

I hereby give clinicians at Whole Living LLC authorization to provide appropriate psychological consultation services, as necessary. I have read the consent to services, including the limits of confidentiality, and the Patient Privacy Notice (HIPAA). I acknowledge I have read the Whole Living LLC Consent to Services form in its entirety. I agree to all terms set forth in this document. I understand I have the right to revoke this consent, in writing, at any time.

Signature of patient or authorized representative Date

Relationship to patient if authorized representative

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of minor assenting to treatment