SANTA ROSA COUNSELING CENTER

INFORMED CONSENT FOR SERVICES

INTRODUCTION

This informed consent document is intended to give you general information about our counseling services, patient rights and risk, and payment responsibility. This is a legal document; please read it carefully before signing. There may be both benefits and risk associated with participation in counseling. Counseling may improve your ability to relate to others, provide a clearer understanding of yourself, your values, your goals, and improve emotional regulation and mood functioning. Although counseling can be beneficial to many people, it may not be helpful for everyone. You may remember unpleasant events, arouse intense emotions, and/or alter relationships. It is essential that you discuss any questions or concerns you might have with your counselor. If you have any questions about signing this document, please ask your counselor. A copy will be provided upon request.

CONFIDENTIALITY

We maintain confidentiality with the ethical guidelines and legal requirements of our profession. Information will not be released without your written consent except under certain circumstances such as information pertaining to suspected child or elderly abuse (Fla. Stat. § 415.504 and 415.1034, respectively), and threatened harm to oneself or others (Fla. Stat. § 491.0147). In select cases, a judge may subpoena protected health information.

When participating in group therapy, confidentiality is encouraged amongst group members but cannot be overseen or enforced by the group facilitator or Santa Rosa Counseling Center. You may want to discuss further limits or exceptions of confidentiality with your counselor.

When participating in couples or family therapy, that treatment unit is considered to be the patient. If there is a request for treatment records, the counselor will seek the authorization from all members of the treatment unit before releasing information to a third party. The counselor may need to share information learned in an individual session with the entire treatment unit if the counselor is to effectively serve the unit being treated. The counselor will use best clinical judgment regarding disclosures made to the treatment unit. If appropriate, the individual may be given the opportunity to make the disclosure to the treatment unit. This *no-secrets policy* is intended to allow the counselor to provide treatment to the treatment unit by preventing, to the extent possible, a conflict of interest to arise where an individual's interests may not be consistent with the interests of the treatment unit. If the counselor is not free to exercise clinical judgment regarding the need to bring this information to the unit during therapy, the counselor might be placed in a situation where they will have to terminate treatment of the unit. This policy is intended to prevent the need for such a termination. If you feel it necessary to talk about matters that you absolutely want to be shared with no one, you may want to consult with an individual counselor who can treat you individually. Members of a treatment unit acknowledge by individual signatures below that each has read this policy, understand it, have had an opportunity to discuss its contents with the counselor, and enter in therapy in agreement with this policy.

RATES AND INSURANCE

The cash rate for Assessment and Treatment Planning is $125. The cash rate for subsequent therapy sessions are as follows: Individual $100, Family and Couples $125, Group $25. You are responsible for paying at the time of service. Payments may be made by cash, check, or credit card. Checks returned for insufficient funds are subject to a $25.00 fee.

Services may be covered by your insurance plan. We participate in most insurance plans and employee assistance programs (EAP). We must obtain current valid proof of your insurance. Co-payments and deductibles are paid at the time of service. This arrangement is part of your insurance plan contract. We will submit your claims and assist in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with these requests. Please notify us of insurance changes before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If you are not insured by a plan we are contracted with or we are unable to verify coverage, payment in full is required. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding coverage. If your insurance company has not paid your claim within 60 days, your balance will be billed and charged to you. **Please be aware that you are responsible for any balance not covered by or paid by your insurance company for any reason, to include billed amounts applied to a deductible.** We reserve the right to use an attorney or collection agency to secure unpaid balances.

APPOINTMENT CANCELLATION

Recognizing that appointment time is limited, we require notice of cancellation one business day prior or 24 hours of the scheduled appointment, whichever is greater. The session fee for a missed appointment or late notice of cancellation is $75.00 and is billed directly to you.

SANTA ROSA COUNSELING CENTER

GROUP THERAPY

Please be present and on time for each group session. When participating in group therapy, tardiness and absences are highly discouraged as they may impact the cohesion and momentum of the group dynamic. Habitual noncompliance to the group schedule may result in you being asked to resign from the group without a refund. We provide courtesy reminders of meeting dates and times by phone, text, and/or email at least one business day prior to each session. If you must miss a group session, please provide notice one business day prior or 24 hours, whichever is greater.

OTHER SERVICES AND FEES

Other professional services such as report writing, telephone conversations, case management/consultations, and court preparation which you have requested is billed $100 per hour on a prorated basis. Fees for reporting writing and court preparation are due prior to service.

If one of our counselors is requested to testify in court and/or deposition, professional fees are billed $125 per hour with a minimum of two hours. Professional fees are to be paid by the patient or the parent/guardian of record even if another party compels the counselor to testify. The fees explained in this paragraph are due prior to service and become non-refundable within 72 hours of service.

ONLINE SCHEDULE PORTAL AND APPOINTMENT CONFIRMATIONS

You will be provided access to **TherapyPortal** so that you may schedule and review your upcoming appointments online. ☐ Activate ☐ OPT OUT

Please provide a courtesy reminder within 48 hours of my scheduled appointments by: ☐ Email ☐ Text ☐ Phone Call ☐ OPT OUT

CREDIT CARD AUTHORIZATION

Santa Rosa Counseling Center requires a credit card authorization on file so that your balances can be settled as they occur. Balances from no-show or late notice of cancellation fees, uncollected copayments, and insurance claim denials will be resolved with your credit card on file. When credit card charges for unpaid balances arise, a statement of the charges will be mailed to you. By signing this informed consent, you are authorizing Santa Rosa Counseling Center to securely maintain your credit card information and any additional payment devices you use for services with Santa Rosa Counseling Center and to use this information to collect outstanding balances for your accounts. This system is certified PCI compliant. We utilize TransArmor which stores security tokens instead of sensitive credit card data. Revocation of this authorization may be submitted in writing. Eligibility of services may be terminated without a valid form of payment on file.

☐ Visa ☐ MasterCard ☐ Discover ☐ AMEX Last Four Card Digits: _____ Office Use: _____

_____

Name as it appears on card (please print) Signature of Cardholder/Authorized User

EMERGENCY

In the event of a mental health emergency and you are unable to contact our office, please contact your physician, emergency phone number 911, or go to the nearest emergency room. If there is a hospitalization outside of our normal operating hours, please contact our office and notify the answering service.

DISCOVERY/REFERRAL SOURCE

☐ Insurance Provider / Employment Assistance Program (EAP) ☐ santarosacounselingcenter.com ☐ Probation / Court

☐ Doctor/Psychiatrist _____ ☐ PsychologyToday / Internet Search ☐ facebook

☐ Department of Children and Families / Families First Network ☐ Family / Friend ☐ Other: _____

ATTESTATION

I certify that I have read, understand, and agree to abide by the information outlined above regarding my eligibility and use of services. I hereby give my consent to assess, evaluate, and provide treatment for myself and/or my child as determined medically necessary. I have had the opportunity to discuss any questions regarding the above information.

_____

Patient of Record Name (please print) Signature Date

_____

Name (please print) Signature Date