Informed Consent for Services

INTRODUCTION

Santa Rosa Counseling Center is a multispecialty group practice of mental health professionals providing therapy, psychiatric care, medication management, and other services. Our providers are committed to ensuring that each and every individual receives the highest quality of care and services possible. This legal document establishes guidelines for your participation in services with us. Please read it carefully and discuss any questions or concerns with office staff and/or the mental health professional before signing.

CONSENT TO TREATMENT

Your signing of this document provides Informed Consent for examination, diagnostic procedures, and treatment, including therapy, psychiatric services, and medication management deemed advisable from the mental health professionals at Santa Rosa Counseling Center. Our mental health professionals include licensed mental health counselors, clinical social workers, psychiatric mental health nurse practitioners, and registered and student interns. Medical care, including therapy and psychiatric services, is not an exact science and no guarantees are made as to the result of such examinations, treatment, and/or diagnostic procedures. While the course of treatment is designed to be helpful, it may be difficult or uncomfortable.

HEALTH INSURANCE BENEFITS AND AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Our providers are preferred network providers with most Health Insurance Plans and Employee Assistance Programs (EAP). Copayments and deductibles are paid at the time of service as part of the insurance provider contract. Payment in full is required when your benefits are not able to be verified. Service claims sent to your insurance provider require disclosure of Protected Health Information including, but not limited to, identifying information, diagnosis, service date, service type, and fees. In some instances, your insurance provider may require documentation such as the treatment plan and clinical notes. Your signing of this document provides specific authorization for the release of this information. Your insurance provider 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. Knowing your insurance benefits is your responsibility. **You are responsible for any balance not covered by or paid by your insurance company for any reason.**

NON-DISCRIMINATION

Santa Rosa Counseling Center does not discriminate in the provision of services to an individual because the individual is unable to pay, because payment for those services would be made under Medicare, Medicaid or the Children's Health Insurance Program (CHIP), or based upon the individual's race, color, sex, national origin, disability, religion, or sexual orientation.

APPOINTMENT REMINDERS AND THERAPYPORTAL

We provide appointment reminders by text message, voice, and/or email using the contact information you provide during registration. This service is a courtesy. Please do not rely upon electronic reminders as the sole reminder for your appointments. To opt out of this feature for security and confidentiality purposes, inform the office staff or your provider. You will be registered with our TherapyPortal for online scheduling, billing, electronic document sharing and signature features. Your signing of this document authorizes the use of your contact information for the purposes of appointment notifications and TherapyPortal features.

CONFIDENTIALITY

We are committed to the confidentiality of your Protected Health Information by the ethical guidelines and legal requirements of our profession. Information will not be released without your written consent except under certain circumstances required by law: Known or suspected abuse, abandonment, or neglect of a child or vulnerable adult must be reported to the appropriate state or county agency (Fla.

Stat. § 415.504 and 415.1034); A provider may have a legal obligation to take protective action if there is reason to believe that there is clear and immediate probability of physical harm to the patient, to other individuals, or to society (Fla. Stat. § 491.0147); and, In certain cases, a judge may issue a court order for the release of Protected Health Information.

When participating in **couples or family therapy**, that treatment unit is considered to be the patient. Requests for treatment records requires authorization from all participants before releasing information. The provider may share information from an individual with all participants when clinical judgment determines it is in the interest of helping the treatment unit. This *no-secrets policy* is intended to mitigate risk of a conflict of interest between the individual and the treatment unit. If an individual has a prevailing interest of confidentiality, the provider may need to refer the individual to another provider or recommend termination of treatment. Confidentiality is encouraged amongst **couples, family, and group therapy** members but is cannot be enforced by the facilitator or Santa Rosa Counseling Center.

REQUESTS FOR DISABILITY

Santa Rosa Counseling Center does not accept patients seeking treatment for the sole purpose of obtaining disability benefits or patients seeking long-term disability benefits. It is possible that after evaluating you your provider may be willing to complete short-term disability paperwork on your behalf; however, your provider is not required to do so and may decline to assist with such a request. Your provider may also require you to schedule a separate follow-up appointment for this purpose. Additional fees are assessed for these services.

MEDICATION MANAGEMENT

To ensure the best reaction to any prescribed medications, please observe the following procedures:

- Always notify your provider of any side effects or problems with medications you are experiencing.
- Never stop or change the dose of a medication without first discussing with your provider.
- Suddenly stopping medication can cause medical problems. For this reason, do not allow yourself to run out of medication.
- If you need a refill before your next scheduled appointment, please call our office 72 hours prior to running out of your medication.
- Keep your scheduled appointments. Although your provider will prescribe you adequate medication until your next visit, cancelled or missed visits can prevent you from having sufficient amounts of medication and make it difficult for your provider to monitor your progress and any complications.
- If you do cancel or miss a visit, be sure to reschedule your next visit before you run out of medication. In general, we will insist that you see your provider before refilling your medication.

PROVIDERS AND STAFF

Your care will be managed by your personal provider or other providers who are not employed by Santa Rosa Counseling Center, but have privileges to care for patients at this center. Your provider's care is supported by a variety of individuals employed by Santa Rosa Counseling Center, including secretarial and billing staff. Your provider may also decide to call in consultants who practice in other specialties and may be involved in your care. Like your provider, those consultants have privileges to provide services for patients at this center but are not employed by Santa Rosa Counseling Center. Santa Rosa Counseling Center supports several graduate programs by providing on-site training and precept opportunities to students.

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. The National Suicide Prevention Hotline at 1-800-273-8255 is available 24/7.

INFORMED CONSENT ATTESTATION

I attest that I have read this document completely, fully understand it, and agree to all described herein. I have had the opportunity to discuss any questions regarding this document.

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Patient Name Signature Date

If you are signing this document as a parent, guardian, or other legal representative of the patient, please indicate your authority to act on behalf of the patient and sign below.

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Name Relationship Signature Date