**Thank you for choosing Presence Counseling Services and /or Presence Developmental Services as your service provider.**

We are committed to serving individuals with Developmental Disabilities.

During your initial session, your provider will review information below related to topics including:

1. your consent to treat you,
2. your financial responsibility,
3. your rights’ and responsibilities,
4. your acknowledgement of our group’s privacy practices, and
5. your authorization to release of any medical information necessary to insurance providers and its agents in order to obtain payment.

If you have any questions or concerns following the review, please do not hesitate to reach out anytime to your provider or call 315-515-5183. Thank you again for choosing Presence!

**Referred Individual giving consent**:

Name:       Address:       Phone #:

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 This form documents that I,      , give my consent to [ ] Presence Counseling Services [ ] Presence Developmental Services to provide treatment to me.

 While I expect benefits from this treatment, I fully understand that no particular outcome can be guaranteed. I understand my discussions about therapy include my provider's evaluation and diagnostic formulation of my challenges, the method of treatment, goals and length of treatment, and information about record-keeping. I have been informed about and understand the extent of treatment, its foreseeable benefits and risks, and possible alternative methods of treatment. I understand that therapy can sometimes cause upsetting feelings to emerge, that I may feel worse temporarily before feeling better, and that I may experience distress caused by changes I may decide to make in my life as a result of therapy. I understand that I am free to discontinue treatment at any time but that it would be best to discuss with my provider any plans to end services before doing so. I understand that the provider cannot provide emergency service and has told me whom to call if an emergency arises. I understand that in any emergency, I may call 911 or go the nearest hospital emergency room. **If I am not able to make my appointment or be on time, I will call at least 24 hours in advance to cancel and re-schedule.**

 I have fully discussed my provider what is involved in services and I understand and agree to the policies about scheduling, fees and missed appointments. I understand that I am fully financially responsible for treatment, which, if I have health insurance, includes any portion of the provider’s fees that are not reimbursed by my insurance. I understand that the frequency of my sessions, that I am fully responsible for payment of all deductibles and co-payments and will decide with my provider to how these payments will be with case, check, or credit card.

 It is my responsibility to provide Presence Counseling Services and Presence Developmental Services with accurate and complete information concerning my primary, secondary, and tertiary insurance providers. **Presence Counseling Services and /or Presence Developmental Services will bill all insurances weekly, and I authorize payment to be made on my behalf to Presence Counseling Services and /or Presence Developmental Services for any services provided**. I am responsible for all the charges of all services provided to me and I authorize Presence Counseling Services and /or Presence Developmental Services to deposit checks received on my account when made out in my name.

**I understand if I receive payment for such services directly from my insurance provider, it is my responsibility to forward this payment and the Explanation of Benefits (EOB) to my Presence Counseling Services and /or Presence Developmental Services provider.**

I understand that I may be asked for payment at the time of services once payment from insurance has been established. I understand if this results in an overpayment to Presence Counseling Services and /or Presence Developmental Services I will be reimbursed.

**I have received a HIPAA Notice of Privacy Practices from the therapist** and if the Notice changes, the changes will apply to any of my protected health information. I understand that information about therapy is almost always kept confidential by the therapist and not revealed to others unless I give my consent. There are a few exceptions as noted in the HIPAA Notice of Privacy Practices.

Details about certain of those exceptions follow:

 1. The therapist is required by law to report suspected abuse or neglect to the proper authorities. The therapist is also mandated to report to the authority’s patients who are at imminent risk of harming themselves or others for the purpose of those authorities checking to see whether such patients are owners of firearms, and if they are, or apply to be, then limiting and possibly removing their ability to possess them.

 2. If I tell the therapist that I intend to harm another person, the therapist must try to protect that person, including by telling the police or the person or other health care providers. Similarly, if I threaten to harm myself, or my life or health is in any immediate danger, the therapist will try to protect me, including by telling others such as my relatives or the police or other health care providers, who can assist in protecting or assisting me.

 3. If I am involved in certain court proceedings the therapist may be required by law to reveal information about my treatment. These situations include child custody disputes, cases where a therapy patient's psychological condition is an issue, lawsuits or formal complaints against the therapist, civil commitment hearings, and court-related treatment.

 4. If my health insurance or managed care plan will be reimbursing me or paying the therapist directly, they will require that I waive confidentiality and that the therapist give them information about my treatment.

 5. The therapist may consult with other therapists about my treatment, but in doing so will not reveal my name or other information that would identify me unless specific consent to do so is obtained. Further, when the therapist is away or unavailable, another therapist might answer calls and so will need to have access to information about my treatment.

 6. If my account with the therapist becomes overdue and I do not pay the amount due or work out a payment plan, the therapist will reveal a limited amount of information about my treatment in taking legal measures to be paid. This information will include my name, patient identification number, address, dates and type of treatment and the amount due.

In all the situations described above I understand that the therapist will try to discuss the situation with me, or notify me, before any confidential information is revealed, and will reveal only the least amount of information that is necessary. I have the right to revoke this Consent at any time by giving written notice of my revocation and submit to Presence Counseling Services and /or Presence Developmental Services.

**I authorize the release of any medical information necessary to my insurance providers and its agents in order to obtain payment.** I understand that my signature requests payment to be made to pay my claim. I authorize direct payment of medical benefits, including medical benefits to which I am entitled to Presence Counseling Services and /or Presence Developmental Services. This is a DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS. This authorization will remain in effect until cancelled by me in writing.

 If I am participating in a managed care plan, I have discussed with the therapist the plan's limits, if any, on the number of therapy sessions. I have discussed with the therapist my options for continuation of treatment when my managed care benefits end.

 I understand that I have a right to ask the therapist about the therapist's training and qualifications and about where to file complaints about the therapist's Professional conduct.

As applicable, I understand that my assigned provider (i.e. LMSW) is working under the clinical supervision of an LCSW or Ph.D.

I understand that I have the right to contact the LCSW or Ph.D. should I have any questions or concerns. (Insert) **LSCW or Ph.D.’s Name and Phone Number**:       OR [ ]  Check if Not Applicable

* **By signing below, I am indicating that I have understood this form and I give my consent to treatment.**
* **By signing this form, I consent authorization for Presence Counseling Services and /or Presence Developmental Services to use and disclose of my protected health information (PHI) to carry out our treatment, payment activities, and health care operations.**
* **I received a copy or was offered a copy, of Presence Counseling Services& Presence Developmental Services Client Rights and Responsibilities.**
* **I received or was offered a copy of Presence Counseling Services & Presence Developmental Services Notice of Privacy Practices. I understand I may request a copy at any time from the Presence Compliance Officer,** **rachellesantana@presencedevelopmental.com****, or get copy from Presence website** [**www.presencedevelopmental.com**](http://www.presencedevelopmental.com) **.”**

NOTE: If the referred individual is a minor, signature of the authorized representative and/or legal guardian

Print or type name here:

