Presence Consent to Treat & Financial Responsibility

First Name: Last Name: Insurance Type: Pick from List
Identify the primary subscriber of the insurance plan if not the referred individual:

Name of Presence Provider: Name of Provider's Supervisor:
Insurance documents will identify the Provider's Supervisor if needed.

Physical Address: Phone #:
If an individual is a minor, identify a legal representative:
First and last name:
Mailing address if different from the referred individual:

This form covers several topics that relate to the authorization for the use and disclosure of health information for your treatment, payment & healthcare operations. This form covers information relevant to:

a. A consent to treat,
b. A financial responsibility,
c. The rights and responsibilities,
d. An acknowledgment of the group's privacy practices, and
e. An authorization to release any medical information necessary to insurance providers, and their agents to obtain payment.

The signature on the form represents an understanding that as the decision-maker for your health care, your personal health information (PHI) is used to assist in making informed choices regarding your services.
Please initial and sign at the end of the document to confirm an understanding of the following:

"I give my consent to Presence Counseling Services and 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 authorize consent to the Direct Assignment of My Rights and Benefits. I authorize the release of any medical information necessary to my insurance providers and their agents to obtain payment.
I understand that my signature to consent requests any insurance payments to be made to pay my claim to Presence Counseling Services and Presence Developmental Services.
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 reschedule. I understand that the provider cannot provide emergency service and has told me whom to call if an emergency arises. I understand that in an emergency, I may call 911 or go to the nearest hospital emergency room.
I understand my discussions about therapy include my provider's evaluation and diagnostic formulation of my challenges, the method of treatment, goals, 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 practical 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 because 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 have fully discussed with my provider what is involved in services, and I understand and agree with the policies about scheduling, fees, and missed appointments.

If you have any questions or concerns, please do not hesitate to reach out anytime to your provider or call the office at 315-515-5183.

I understand that I am fully financially responsible for the treatment, which, if I have health insurance, includes any portion of the provider's fees that are not reimbursed by my insurance. I understand the frequency of my sessions, that I am fully responsible for payment of all deductibles, and co-payments, and will decide with my provider how these payments will be paid with cash, check, or credit card. 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.

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 payors. Presence Counseling Services and Presence Developmental Services will bill all insurances, and this is authorizing payment to be made on my behalf to Presence Counseling Services and /or Presence Developmental Services for any services provided.
Notice: If during the insurance eligibility verification process, discovery is made that the primary insurance for the referred individual is an out-of-network plan such as BCBS or Excellus, Presence staff will send an "Out-of-Network Notice to Primary Subscriber." This Notice is sent because the third-party plan may send $0 or partial payment for Presence services to the primary subscriber's home address, and this payment MUST be mailed or dropped off at the Presence business office. If the primary subscriber receives insurance documents and insurance payment, please email billing@presencedevelopmental.com alerting the Claims management department to work out a plan to get the insurance payment to the office at 115 Fall Street, Seneca Falls NY 13148.

I am responsible for all the charges of all services provided to me and I authorize Presence Counseling Services and Presence Developmental Services to deposit checks received on my account when made out in my name. I understand if my insurance plan sends a payment for services, or other insurance documentation (such as Explanation of Benefits, Summary of Benefits, Monthly Summary) and lists Presence Counseling Services or Presence Developmental Services, it is my responsibility to forward this documentation, and payment to: Claims Management, Presence Services.

I am authorizing the direct payment of medical benefits, including medical benefits to which I am entitled, to Presence Counseling Services and/or Presence Developmental Services. This authorization will remain in effect until it is canceled by me in writing or until discharge.
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 understand that if the billing account becomes delinquent, with an outstanding balance over $1,500.00, the services established in my treatment plan may be paused and closed until an action plan is established and the billing account falls below the balance of $500.00.

I have been offered a copy of the HIPAA (Health Insurance and Portability and Accountability Act) Notice of Privacy Practices. If the Notice changes, the changes will apply to any of my protected health information (PHI). I understand that information about therapy is 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 and details are below regarding the therapist's role as a mandated reporter:

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 those authorities to check to see whether such patients are owners of firearms and if they are, or apply to be, then limiting and 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 about the person or other health care providers. Similarly, if I threaten to harm myself, my life, or my health in any immediate danger, the therapist will try to protect me, including by telling others such as my relatives 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 reimburses me or pays 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 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, type of treatment, and the amount due.

In 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 necessary. I have the right to revoke my consent at any time by giving written notice of my revocation and submitting it to Presence Counseling Services and Presence Developmental Services.

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.

I understand that my assigned provider may be working under the clinical supervision of an LCSW (Licensed Clinical Social Worker), or Ph.D., and I have the right to contact the provider's clinical supervisor if I should have any questions or concerns.

Initials & Signatures * If signatures are not available, identify the date of review with the individual or legal representative to obtain verbal consent to treat.

1. I give my consent to treatment. (initials)
2. I consent to the authorization for Presence Counseling Services and Presence Developmental Services to use and disclose my protected health information (PHI) to carry out our treatment, payment activities, and healthcare operations. (initials)
3. I have received and/or been offered a copy of the Presence Counseling Services& Presence Developmental Services Client Rights and Responsibilities. (initials)
4. I have received and/or been offered a copy of Presence Counseling Services & Presence Developmental Services Notice of Privacy Practices and I understand that I may request a copy at any time from the Presence office, info@presencedevelopmental.com, or get a copy from the Presence website www.presencedevelopmental.com. (initials)

Individual's Signature: Date:

Print name:

☐ **If the individual is a minor, obtain the signature of an authorized representative and/or legal guardian:**

Legal representative Signature: Print Name:

Email address:

Thank you for choosing Presence Counseling Services & Presence Developmental Services!