



HOPELIFE BEHAVIORAL & WELLNESS SERVICES LLC.
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WEST HARTFORD, CT 06107
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CONSENT TO TREAT and AGREEMENT FOR SERVICES

Welcome to Hopelife Behavioral and Wellness Services. This document contains important information about our services and business policies. Please take time to read thoroughly and have any questions ready to discuss with your clinician.

CONSENT TO TREATMENT: By signing as the Client or the Guardian of said Client, I acknowledge that I have read, understand, and agree to receive treatment from a clinician of Hopelife, that may include assessment, psychotherapy, medication management and/or case management. I have been given the opportunity to address any questions or request clarification for anything that is unclear to me. I am voluntarily agreeing to receive a mental health assessment and/or treatment and services for myself (or my child) and I understand that I may stop treatment or services at any time. I further understand that sessions can occur in the office or telehealth, as agreed upon between the client and clinician.

Client Rights

- You have a right to be informed of the qualifications of your clinician, including education, experience, certifications and license
- You have a right to receive an explanation of services offered, your time commitments, fees, and billing policies prior to receipt of services
- You have a right to have all that you say treated confidentially and be informed of any state laws placing limitations on confidentiality in the counseling relationship
- You have a right to ask questions about treatment techniques and be informed of your progress
- You have a right to participate in setting goals and evaluating progress
- You have a right to be informed of how to contact the counselor in an emergency situation
- You have a right to request copies of your mental health record
- You have a right to contact the appropriate professional organization if you have complaints relative to the clinician's conduct

Client Responsibilities

- Set and keep appointments with your clinician. Adhere to cancellation policy below
- Pay your fees, such as co-pays, in accordance with insurance coverage or as otherwise arranged with your clinician
- Establish and communicate your goals for treatment
- Follow through with agreed upon goals
- Keep your therapist informed of your progress towards meeting your goals.

Initials BR

LIMITS OF CONFIDENTIALITY: All information disclosed in session and in written records pertaining to sessions are confidential and may not be revealed to anyone without your (client's) written permission, except where disclosure is required by law, such as mandated report of abuse or imminent danger to self or others. Additionally, when submitting claims to insurance carriers such information such as diagnosis, symptoms and treatment progress must be included to obtain authorization for services.

CANCELLATION POLICY-There is a 24-hour cancellation policy. All clients are required to notify their provider either through the office line (802-565-1755), work cell (860-849-9004) or email (hopelifebehavioral7@gmail.com) that they intend to cancel/reschedule their appointment 24- hours prior to their scheduled appointment. **Clients who do not follow the 24- hour cancellation policy or are a no call/no show will be subject to a \$150. 00 fee.** The first incident may be waived at the discretion of the clinician. No fee will be charged for clients on Medicaid (Husky). All clients with commercial plans will be subjected to this charge.

NO CALL/ NO SHOW- It is understood that people forget, however, clients that fail to keep two appointments without following the cancellation policy may be discharged from services at the discretion of the clinician. All established clients who are discharge will receive a 30-day supply of medications. **New clients who no call/no show for their initial intake may not be given an opportunity to reschedule their missed intake appointment. and, if are on a commercial plan for insurance, will be charged a \$150.00 fee.**

ZERO TOLERANCE- There is zero tolerance for behaviors that are inappropriate, unsafe and threatening. Per the clinician's judgment, if a client exhibits any of these behaviors, they will be discharged immediately from Hopelife and will no longer receives services.

FEES: Hopelife will submit claims to insurance on your behalf. Please note that not all claims are accepted by insurance carriers. In this event, it is the responsibility of the client or legal guardian to pay unpaid claims. Please note that Hopelife will attempt to verify insurance benefits prior to treatment however in the event that insurance is invalid or treatment not covered, the client/legal guardian is expected to pay. There will be a \$35.00 charge for any return checks.

CO-PAYS-All co-pays and deductibles are due at the time of services.

MEDICATION REFILLS-Refills will NOT be authorized if you have missed any appointments within the 30 days of when your refill is due. Controlled medications without followup appointments will not be refilled.

SERVICES- Services provided outside of regularly scheduled appointments such as report writing and completion of SSI/Disability forms will be charged at \$100 per hour. If you request or if your clinician is required to participate in a legal proceeding (e.g. divorce or DCF hearing), you will be expected to pay for your clinician's time at a rate of \$100 per hour and pay for transportation costs (including all costs incurred if called to testify by another party). Fees must be paid within 14 days of service provided.

RELEASE OF RECORDS- Clients may request their records with a fee of .65 cents per page. All records will be printed and mailed.

AFTER HOUR EMERGENCIES: In the event of a medical or psychiatric emergency, the client must call 911. Clinicians are not available after hours. If you leave a message with your clinician after hours, your call will be returned within the first business day to arrange an emergency session.

Initials_____

HIPAA COMPLIANCE AND PATIENT CONSENT: Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. This notice contains a patient's rights under the law. You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations. By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing. However, such a revocation will not be retroactive.

By signing, I attest that I have reviewed and understand Hopelife's HIPAA Policies and Notice of Privacy Practice

By signing, I give informed consent for treatment of (client name) _____

By signing, I have read and agree to adhere to Hopelife's policies as noted above.

Client Name (print) _____ Date _____

Client/Legal Guardian Signature _____

If signing as legal guardian, note relationship to client: _____