THERAPY YOUR WAY
COUNSELING AND CONSULTING SERVICES

Consent to Treatment

I acknowledge that I have received and understand the "Information for Clients" brochure and/or other information about the therapy I am considering, and I have had an opportunity to have all my questions answered fully. _____

I do hereby seek and consent to take part in the treatment by the therapist named below. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process. _____

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist. Discretion to discontinue therapeutic relationship due to the following, but not limited to (best fit practices, best interest of client etc). _____

I am aware that I may stop my treatment with this therapist at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.) _____

I know that I must call to cancel an appointment at least 24 hours before the time of the appointment. If I do not cancel or do not show up, I will be charged for that appointment. _____

I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive. I understand that if payment for the services I receive here is not made, the therapist may stop my treatment. _____

My signature below shows that I understand and agree with all of these statements.

_____ _____

Signature of Client (or person acting for client) Date

_____ _____

Printed name Relationship to client if not self Date

I, the therapist, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____

Signature of Therapist Date

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Parent/Guardian Name: _____ Social Security #: _____

I request and authorize Therapy Your Way Counseling and Consulting Services to release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

This request and authorization applies to: Healthcare information relating to the following treatment, condition, or dates:

_____

_____

- Other:_____
- Yes, I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.
- No, I do not authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient/ Guardian Signature: _____ Date :_____

***THIS AUTHORIZATION EXPIRES ONE YEAR AFTER IT IS SIGNED.

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NO-SHOW/CANCELLATION POLICY

Our office requests a 24-hour notice of an appointment cancellation. In the event that a notification was not made, there will be a $50.00 fee added towards the future appointment.

This fee is expected to be paid before being seen by the therapist. When (3) No-Shows/Cancellations have been accumulated within a calendar year, the client will be discharged from the practice.

Please help us to better serve you and other clients by keeping all scheduled appointments.

I certify that I have read and understand the "No-Show/Same Day Cancellation Policy" and agree to all terms and conditions as stated above. _____ (Initial)

Client Signature:
_____Date:_____

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Confidentiality in Psychotherapy

The signature below attest to the fact that we have each read, discussed , understand and agree to the information present in the Confidentiality in Psychotherapy. A digital or hard copy has been received by me, for my records. _____ (Initial)

Client's Signature: _____ Date:_____

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HIPPA Notice of Privacy Practice

I have received and reviewed a copy if HIPPA Notice of Privacy Practices from Therapy Your Way Counseling and Consulting Services. _____ (Initial)

Client's Signature: _____ Date:_____

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FINANCIAL AGREEMENT

_____I understand and agree that it is my responsibility to understand my benefits for mental health services, to be aware of any co-payment, deductible, pre-authorization, or limits that apply to my plan, and to inform my therapist of these.

_____I understand that any co-payment is due at the time of service. • If my insurance coverage changes during the course of treatment, I agree to notify Therapy Your Way Counseling & Consulting, LLP prior to the change.

_____In the event that I fail to communicate any information regarding my insurance plan(s), co-pays, deductibles, preauthorization or changes, I agree that I will be responsible for any charges that are denied as a result.

_____I understand that I am responsible for all charges whether or not paid by insurance. This includes amount reclaimed by insurances, whichever the date of the re-claim.

_____I certify that I (or my dependent) have insurance coverage(s) as noted above and only these and I assign directly to Therapy Your Way Counseling & Consulting, LLP all insurance benefits, if any, otherwise payable to me for services rendered.

_____I hereby authorize the healthcare provider to release to my insurance carrier and to the healthcare provider's billing service all information needed to secure the payment of benefits, and to mail patient's statements. I authorize the use of this signature on all insurance submissions.

_____I certify that I have read and filled out this form completely to the best of my knowledge.

_____ _____ _____

Responsible Party Signature | Relationship to client | Date

_____

Print Name

THERAPY YOUR WAY
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Patient Rights & Responsibilities

- Patients have the right to be treated with personal dignity and respect.
- Patients have the right to confidentiality of information (note exceptions in "Consent to Treat" Form).
- Patients have the right to reasonable access to care, regardless of race, religion, gender, sexual orientation, ethnicity, age, or disability.
- Patients have the right to individualize treatment.
- Provision of service within the least restrictive environment possible.
- An individualized treatment or program plan.
- Patients have the right to voice complaints or appeals about managed care company or the care provider.
- Patients have the responsibility to give their provider and manage care company information needed in order to receive appropriated care.
- Patients have the responsibility to follow their agreed treatment plan and instruction for care.
- Patients have the responsibility to participate, to the degree possible in understanding their behavioral health problems and developing with their provider mutually agreed upon treatment goals.

*** Signature below indicates that I have read and understand this document.**

Client / Guardian Signature: _____ Date:_____

provide you only with an electronic copy of their PHI, not direct access to their electronic health record systems. The 2013 Amendments also give you the right to direct **Therapy Your Way Counseling and Consulting Services,** to transmit an electronic copy of PHI to an entity or person designated by you. Furthermore, the amendments restrict the fees that **Therapy Your Way Counseling and Consulting Services,** may charge you for handling and reproduction of PHI, which must be reasonable, cost-based and identify separately the labor for copying PHI (if any). Finally, the 2013 Amendments modify the timeliness requirement for right of access, from up to 90 days currently permitted to 30 days, with a one-time extension of 30 additional days.

X. NOTICE OF PRIVACY PRATICES (NPP) **Therapy Your Way Counseling and Consulting,** must contain a statement indicating that most uses and disclosures of psychotherapy notes, marketing disclosures and sale of PHI do require prior authorization by you, and you have the right to be notified in case of a breach of unsecured PHI.

XI. EFFECTIVE DATE OF THIS NOTICE I acknowledge receipt of this notice on the date written below.

Signature: _____

Date: _____

-------Signature page of HIPPA Notice. Signature indicates policy has been reviewed and email version sent to client for their records. Copy of policy can be requested as well.