Welcome to South Shore Mental Health Counseling Services, P.C.

Name:_____ Date:_____

CONSENT TO TREATMENT

I the undersigned, hereby attest that I have voluntarily entered into treatment, or give my consent for the minor or person under my legal guardianship mentioned above, at South Shore Mental Health Counseling Services, hereby referred to as SSMHCS. Further, I consent to have treatment provided by a mental health counselor or intern in collaboration with his/her supervisor OR by an independently licensed contracting psychiatrist, nurse practitioner, or social worker subletting space at this facility. The rights, risks and benefits associated with the treatment have been explained to me. I understand that the treatment may be discontinued at any time by either party. SSMHCS encourages that this decision be discussed with the treating clinician. This will help facilitate a more appropriate plan for the future.

Recipient's Rights: I certify that I have received the Recipient's Rights notice and certify that I have read and understand its content. I understand that as a recipient of services, I may get more information from the Recipient Rights Advisor, the Director.

Non-Voluntary Discharge from Treatment: A client may be terminated from SSMHCS non-voluntarily, if A) the client exhibits physical violence, verbal abuse, carries weapons, or engages in illegal acts at the facility, and/or B) the client refuses to comply with stipulated program rules, refuses to comply with treatment recommendations, or does not make payment or payment arrangements in a timely manner. The client will be notified of the non-voluntary discharge by letter. The client may appeal this decision with the Director or request to re-apply for services at a later date.

Client Notice of Confidentiality: The confidentiality of patient records maintained by SSMHCS is protected by Federal and/or State laws and regulations. Generally, SSMHCS may not disclose to a person outside SSMHCS that a client is a recipient of services unless 1) the patient consents in writing, 2) the disclosure is allowed by court order, or 3) the disclosure is made to medical personnel in a medical emergency, or to qualified personnel for research, audit or program evaluation.

Violation of Federal and/or State law and regulations by a treatment facility or provider is a crime. Suspected violations may be reported to appropriate authorities. Federal and/or State law and regulations do not protect any information about a crime committed by a patient either at the facility, against any person who works at the facility, or about any threat to commit such a crime. Federal law and regulations do not protect any information about suspected child (or vulnerable adult) abuse or neglect, or adult abuse from being reported under Federal and/or State law to appropriate State or Local authorities. Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful. It is the duty of SSMHCS to warn any potential victim, when a significant threat of harm has been made. In the event of a client's death, the spouse or parents of a deceased client have a right to access their child's or spouse's records. Professional misconduct by a health care professional must be reported by other health care professionals, in which related client records may be released to substantiate disciplinary concerns. Parents or legal guardians of non-emancipated minor clients have the right to access the client's records. When fees are not paid in a timely manner, a collection agency will be given appropriate billing and financial information about the client, not clinical information. My signature below indicates that I have been given a copy of my rights regarding confidentiality. I permit a copy of this authorization to be used in place of the original. Client data of clinical outcomes may be used for program evaluation purposes, but individual results will not be disclosed to outside sources.

FINANCIAL POLICY

As a service to you, SSMHCS may bill insurance companies and other third-party payers, but cannot guarantee such benefits or the amounts covered, and is not responsible for the collection of such payments. Clients are responsible for payments regardless of any insurance company's arbitrary determination of usual and customary rates. Insurance companies may deny payment for treatments they deem unnecessary, in this instance the client is responsible for payment. Insurance deductibles and co-payments are due at the time of service. Your signature below indicates authorization for SSMHCS to bill your insurance company for reimbursement unless fees are paid in full at the time of services.

Clients are responsible for payments at the time of services. The adult accompanying a minor (or guardian of the minor) is responsible for payments for the child at the time of service.

Missed appointments or cancellations less than 24 hours prior to the appointment are charged at a rate equal to your session fee of $_____. You will be held responsible for this fee. Kindly give adequate notice.

Payment methods include cash, check, or credit card. Questions regarding the financial policies can be answered by the Office Manager. **Payments not received after 120 days are subject to collections.** A 1% per month interest rate is charged for accounts over 60 days. There will be a $30 fee for checks returned due to insufficient funds.

I consent to treatment and agree to abide by the above stated policies and agreements with SSMHCS.

_____ _____

Signature of Client or Legal Guardian Date