# OFFICE POLICIES AND CONSENT TO TREATMENT

## OFFICE POLICIES

We are committed to providing you with quality care. The following office policies are for your information. Should you have any questions or concerns regarding these policies, please speak with your therapist as soon as possible.

**Insurance:** If certain insurance carriers or HMO's insure you, this office can bill the insurance carrier directly to the extent of your policy's coverage for psychotherapy sessions. Co-payments and deductibles are the client's responsibility to pay directly at the time of service. Services provided beyond the limits of annual coverage are to be paid directly by the client. Unless otherwise arranged, clients covered by all other insures must pay for services. privately and obtain reimbursement directly from the insurance company.

**Fee schedule:** Payments are due at the time of appointment unless otherwise agreed upon. The following schedule lists the standard fees most commonly requested services:

Diagnostic Evaluation (45-50 minutes)... $200.00
Family/Couple Psychotherapy (45-50 minutes)... $145.00
Individual Psychotherapy (45-50 minutes)... $125.00
Group Therapy (45-50 minutes)... $175.00

**Cancellations and Missed Appointments:** If you are unable to keep a scheduled appointment, 24 hour notice is required for cancellation. Failure to attend a scheduled appointment will result in being charged the full fee unless prohibited by federal regulations. This is not billable to your insurance company, and is payable at your next appointment. Please consult with your therapist regarding his or her particular cancellation and missed appointment policy.

**Emergency:** If for some reason you are not able to call us, you should go to the nearest emergency room or crisis center.

**Contact with Primary Care Provider:** By signing below I give my therapist permission to communicate with my primary care physician _____ and/or treating psychiatrist/nurse practitioner _____ regarding my treatment to assure continuity of care, if necessary.

_____ is an independent clinician and will be providing treatment to you or your family members in that capacity. Emotional Wellness Counseling, Inc. is an association of independent practitioners for the sole purpose of cost sharing expenses. Your therapist may have you sign a separate document for this purpose.

## CONSENT TO TREATMENT

I have read all of the information on this sheet and have completed the answers on the other side. I am also aware that my rights as patient are posted in the waiting area for my review. I have been offered a copy of Emotional Wellness Counseling, Inc. Notice of Privacy Practices and understand that I may discuss any questions about this notice with my therapist. I certify that this information is true and correct to the best of my knowledge. I will notify you of any changes in my health insurance status or any information requested. Payment is required within 30 days from the date of bill. I acknowledge that I have received a copy of the Notice of Privacy Practices and Business Policies.

If you have any concerns, complaints or questions about your treatment you are encouraged to share them with your therapist.

By signing this document, I acknowledge that I have read the above Agreement of Understanding and give Informed Consent to treatment services as well as agree to the policies set forth in the Agreement. I hereby give permission to initiate and conduct treatment for myself and/or family member(s).

_____ _____

Client Signature (if minor Parent, or Legal Guardian) Date

_____ _____

Client Signature (if minor Parent, or Legal Guardian) Date

_____ _____

Client Signature (if minor Parent, or Legal Guardian) Date

# Emotional Wellness Counseling, Inc.

3267 Acushnet Ave.
New Bedford, MA 02745
508.995.1400

COORDINATION OF CARE COMMUNICATION FORM

Date: _____ MD Name: _____

Patient: _____ MD Address: _____

_____

DOB: _____ Phone: _____

This information is provided to facilitate coordination of treatment/continuity of care.

I saw this patient on: _____

DSM IV Diagnosis: _____

The recommended treatment is:_____

_____

Please call me if you need to discuss this case further or if you require further information.

_____ _____ _____

Signature Name (printed) Degree/License

PATIENT AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____ do hereby authorize _____ to release and exchange medical/psychiatric and psychological information pertaining to me/my child with my primary care physician and my psychiatrist. This authorization is for the exchange of information between the PCP, psychiatrist, and behavioral health clinician and vice versa. This information will include information concerning social history, diagnosis, treatment plan, tests and medications. This authorization will expire no later than one year from the date of signature.

Signed: _____ Date: _____

NOTICE TO RECIPIENT: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR, Part 2) an d/ or state law. I accordance with Federal and State law requirements, the information received pursuant to this document is confidential and recipient is prohibited from making further re-disclosure of this information to any other person or entity, or to use it for any purpose other than as authorized herein, without the written consent of the person to whom it pertains or as otherwise permitted by law. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

Emotional Wellness Counseling, Inc.

RELEVANT MEDICAL INFORMATION

Today's Date: _____

Name:_____ DOB _____

Address:_____ City/State/Zip _____

Home Phone: _____ Cell Phone: _____

Primary Care Physician and Phone: _____

Date of your last physical exam: _____

Please check all that apply:

- ☐ Heart disease/circulatory disorder
- ☐ High blood
- ☐ Bleeding
- ☐ Anemia
- ☐ Lung Disease
- ☐ Kidney Disease
- ☐ Stomach or Intestinal Disorder
- ☐ Liver Disease
- ☐ Seizure Disorders
- ☐ Dts Delirium Tremors
- ☐ Blackouts
- ☐ Memory Problems
- ☐ Hearing Problems
- ☐ Previous Pregnancies
- ☐ Walking problems or Poor balance
- ☐ Numbness/Tingling
- ☐ Diabetes
- ☐ Menstruation Problems
- ☐ Breast Problems
- ☐ Genitalia Problems
- ☐ Bone Disease
- ☐ Cancer
- ☐ Tuberculosis
- ☐ Venereal Disease (Herpes, Gonorrhea, Etc.)
- ☐ Headaches
- ☐ Visual Problems
- ☐ Dizziness/Fainting
- ☐ Are you or could you be pregnant now?

Please list any allergies (food, medication, other) that you have:

_____

_____

Please List any operations that you have had:

_____

_____

Please list any/all medication that you are currently taking:

_____

_____

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FOR OFFICE USE ONLY

Medication Changes: Date:

_____

_____

_____

_____