# Marriage Resource Center

# Consent for Treatment

INFORMATION FOR PATIENTS

Welcome to our practice, Marriage Resource Center. This document (the Agreement) contains information about our professional services and business policies and answers some frequently asked questions. After you have had an opportunity to read it, your therapist and you will discuss it together so that any question you may have can be answered.

All the therapists in this practice are licensed to practice in the State of Pennsylvania. All persons are eligible for our services, regardless of race, ethnicity, gender, sexual orientation, disability, religion, or creed. We use a number of different approaches in our work and will discuss with you the strategies that we believe may best meet your needs.

RIGHTS AND INFORMED CONSENT

Psychotherapy works best when it is a cooperative and collaborative effort. It calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home. You have the right to be informed about your therapy, any risks it might involve, and what alternatives there might be. You have the right to be informed about your therapist's qualifications to treat you. You have the right to request or to refuse any particular technique or to withdraw from therapy at any time. If you could benefit from any treatments we cannot provide, it is our ethical obligation to offer to refer you to someone who can help you. If you wish to examine your records, your therapist will go over them with you and answer any questions you may have. To do this, we request one week notice in order to review the record and prepare to discuss it with you. Your feedback about what you like or do not like about the therapy is always welcome. Should you at any time feel dissatisfied or concerned about your work with your therapist, please speak with your therapist as soon as possible. If you feel the discussion does not resolve a problem and would like further assistance, you may speak with the Director of the practice, Jill Ballman, or your therapist will help you to find another professional.

Psychotherapy has helped many people, but success is never guaranteed. In fact, there are some risks in treatment. As problems or difficulties are faced, they sometimes seem to get worse. As people work to improve the quality of their lives, they sometimes make decisions which can lead to painful outcomes or conflict with others. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. An important part of our work together will be to discuss the benefits and risks of the choices you make. You are the final judge of the benefits and risks that therapy holds for you.

## MY ROLE AS YOUR COUNSELOR

It is important to understand what to expect from your counselor, and what not to expect. First, a counselor's role can be best explained as a neutral facilitator of safe feedback and communication. As your couple's therapist, it is not productive for the facilitator to validate one's position so that they can feel that they are "right" within a particular argument with your partner, and that their partner is wrong. Rather, it is much more accurate to think of my job as helping you understand what was going on inside that led you to the behaviors or beliefs you hold in your relationship and to facilitate a clear, calm, and compassionate understanding between you and your partner. I promise to do my best to give equal amounts of feedback as possible, and to realize that whatever issues are present are not to be judged or criticized. It takes bravery to be willing to look at oneself, and I want to invite you to embrace your courage and you embark on this process!

## CONTACT BETWEEN SESSIONS

Each psychotherapist in our practice keeps a different schedule, to better accommodate the different needs of different patients. Please ask your therapist for his/her schedule. Calls are usually returned to patients on the days that the therapist is in the office. Please leave messages on the voice mail of the therapist with whom you wish to speak, or you can contact the business office to speak with the director.

IN CASE OF EMERGENCY: If your therapist is unavailable when you call, please contact the Scranton Counseling Center at 570-348-6000. If you are at serious or imminent risk or have already harmed yourself, you should call 911 or go directly to an emergency room and call us again from there.

Current client's of Jill Ballman may call 570-878-3375 if she can not be reached through the office number and it is of an urgent matter. However, please do not send text messages to this number as they are not confidential.

## FEES AND PAYMENT

The length of individual and family sessions is 45 minutes and is $95/$75 (family/Individual). That time has been specifically set aside for you. Should you be unable to come to a scheduled appointment, we ask that you provide at least 24 hours notice of cancellation so that we have an opportunity to offer other clients the appointment time you no longer need. Since we are unlikely to fill your appointment time with less than 24-hour notice, we ask your cooperation and understanding in paying the late cancellation or missed appointment fee of $50 if you provide less than 24 hours notice, even if you are sick. The one exception to this requirement is in the case of dangerous weather. We do not require 24 hour notice of cancellation when there is dangerous weather, but if you do not keep an appointment in bad weather, you will be charged if you have not cancelled. Our answering machine is working 24 hours per day, so cancellations can take place on weekends for Monday appointments, as long as 24 hour notice is given. Our answering machine records the time and date of your calls.

It is expected that appointments for psychotherapy will be kept by you, as part of your commitment to treatment. Therefore, if you cancel or miss three appointments, or if there is a pattern of canceling or missing appointments, then we will talk with you about taking a break from treatment until such time as you are able to commit to regular appointments.

You are financially responsible for all costs for the care you receive, except those services for which you are eligible through your insurance coverage. Clients/Patients are expected to pay any known co-payments, deductibles, co-insurances, and non-covered amounts when services are received. Our office manager is happy to answer any questions you may have about your insurance.

All requests for payments are based on estimated amounts and are not considered final billing totals, as we will adjust your bill after final payments have been received from insurance carriers. Insurance claims are submitted as a courtesy service and do not relieve you of financial responsibility.

The MRC adheres to the strict ethical standards of the American Association of Marriage and Family Therapists (AAMFT) and the American Counseling Association (ACA). Please refer to the Notice of Privacy Practices and Client's Rights for further information regarding your confidentiality and what you should expect as a client of the MRC. If you are attending couples counseling, you must be aware that the "couple" are considered the client and neither party can waive the confidentiality rights of the other party.

*By signing this form I acknowledge that I have received, read and understand the Consent for Treatment form. I have had an opportunity to ask questions and receive answers. I do hereby seek and consent to take part in treatment by the MRC. I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this counselor. I am aware that I may stop my treatment at any time. It has been made known to me that should I find myself involved in legal proceedings my counselor will not testify on my behalf. I am aware that I am responsible to pay any fees not covered by my insurance. I know I must call to cancel or reschedule an appointment at least 24 hours in advance if I wish to avoid financial responsibility for the session. I know I may receive confirmation calls or letters of follow-up on missed appointments. I understand that my primary therapist is part of a treatment "team" and my information may be used during case consultations, however my name and personal identifying information will not be disclosed without my written consent.*

**My signature on this document shows that I understand and agree with the above conditions and statements.**

_____

Client signature Date

_____

Counselor signature Date

# HIPAA CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

The Health Insurance Portability and Accountability Act of 1996 is a set of federal laws designee to safeguard your health information. These privacy laws serve several purposes. For example, they establish how your health information can be used by us-your health care provider. They also identify instances when your permission is required to disclose your health information to other persons. Additionally, they identify your rights, when it comes to the handling of your health information.

These privacy laws allow us-as your health care provider-to use your health information in several ways. For example, in order to provide health care services to you, we are required to maintain certain records about the treatment that we provide to you. These privacy laws allow us to use your health information to maintain these records. We are also allowed to use your health information to seek payment for the services that we provide to you. Additionally, we are allowed to use your health information in the course of certain of our day-to day operations.

These privacy laws allow you to ask us to restrict how your health information is used in certain circumstances. For example, if you do not want us to call you at a certain phone number, you may request that we use an alternate phone number if we need to contact You. We will work with you if you have any reasonable requests on how you would like your health information to be used, but we would like to make you aware that these privacy laws do not require us to agree to your requests in all situations. If you have any reasonable requests on the use of your health information, please ask to speak to our Privacy Officer.

These privacy laws also allow us to seek your written consent for us to use and disclose your health information in order to: 1) provide treatment to you, 2) seek payment for services that we provide to you, and 3) for certain day-to-day operations of our organization. We are voluntarily seeking your consent to use and disclose your health information for the purposes of treatment, payment, and our health care operations because we want you to know about your rights-and our rights-regarding the handling of your health information. If you have any questions about how we may use or disclose your health information, or about the records that we must maintain about you, please ask to speak with our Privacy Officer.

I have read and understand the information contained within this HIPAA Consent.

CLIENT'S SIGNATURE _____ DATE _____

Jill Ballmer

STAFF SIGNATURE _____ DATE _____

I have been offered a copy of this form, which I have (please initial one) _____ ACCEPTED

_____ REFUSED

# Insurance Information and Release

First Name:_____ Middle Initial___Last Name_____

Address:_____ City:_____

State:_____ZipCode:_____ Phone: _____

Date of Birth_____Sex__M__F

Primary Insurance Name:_____

Insurance ID#_____group#_____

Relationship: ___Self ___Spouse ___Child ___Other

Insured Name if not Patient_____Insured Date of Birth_____

ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize direct payment of mental health benefits to Marriage Resource Center, for services rendered. I understand that I am financially responsible for any balance not covered by my insurance.

I also authorize Marriage Resource Center, to release any medical/mental health information that may be necessary for either medical care or in processing applications for financial benefit. I request that payment of authorized benefits be made on my behalf. A photocopy of these assignments shall be valid as the original. I am aware and do consent and authorize Marriage Resource Center, to disclose information pertaining to my identity, diagnoses, and treatment to the Utilization Review Manager and/or any authorized Utilization Review/Managed Care Company or subcontractor employed by my insurance company. This information needs to be disclosed for the purpose of obtaining health insurance payments for charges incurred by the patient as a result of treatment at Marriage Resource Center.

I am aware that my records are protected under the Health Insurance Portability and Accountability Act of 1996 (45CFR,Parts 160 and 164), Federal regulation 42 CFR, Part 2 (Confidentiality of Alcohol and Drug Abuse Treatment), and under the General Laws of the State of Rhode Island and cannot be disclosed without my written consent except as otherwise specifically provided for by law. I understand that by law I need not consent to the release of this information. However, I choose to do so willingly and voluntarily for the purpose specified above.

_____

Signature of Client/DATE