

## CONSENT FOR TREATMENT

**SERVICES:** We adhere to the current local and national standards for behavioral health care and provide evidence-based treatments for mental health and developmental conditions. Services we provide include Medication Management, Counseling, Developmental Disability Services, and Family/Peer Supports. While we provide evidence-based treatments that are shown to improve symptoms, there is no guarantee that any service or medication provided will completely alleviate the symptoms addressed. Risks associated with these services include a worsening of your condition. Services are limited because of third party/Medicaid payer requirements and may be modified or ended due to payer policies. Third parties are billed based upon our fee schedule. You have the right to select your service provider, refuse these services and withdraw this consent at any time.

**APPOINTMENTS:** Office visits are by appointment only. When you call for an initial appointment, our Office Manager will ask a few questions regarding the nature and urgency of your concern or problems.

**CANCELLATIONS:** We request that cancellations be made at least 24 hours in advance of scheduled appointments. We reserve the right to charge a late cancellation fee of \$70 (as permitted by your insurance carrier). It is your responsibility to keep the appointment you make.

**TIMES:** Appointments take approximately forty-five to fifty-five minutes.

**EMERGENCY AND AFTER HOURS COVERAGE:** If a life-threatening emergency arises after business hours, please proceed directly to the nearest emergency room or call 911. You may access the Suicide and Crisis Lifeline by texting or calling 988. An individualized safety plan will be developed at the initiation of treatment.

**CONFIDENTIALITY:** Your privacy is our priority and is protected by state and federal law. Limited confidential information can be released by the clinic without your consent in specific situations involving: 1) suspected neglect or abuse of a child, 2) life-threatening danger to you or other, as in cases of very high risk of suicide or threats of bodily harm against others, 3) if so ordered by a court or required by applicable law, and 4) if a medical emergency occurs while you are at the clinic and you require emergency treatment.

**COORDINATION OF CARE:** We will not release any records without your written consent, other than in the following circumstances: 1) Upon request from your referring physician we will send reports for coordination of care. You must tell us otherwise if you do not desire communication with your referring physician. 2) Your record may be reviewed by your insurance company. Your insurance claims will be submitted electronically or mailed with diagnostic code and a code for the type of treatment rendered. 3) It is at times necessary for providers within this agency, or contracted with this agency, to discuss your case in order to provide the best quality of care.