Aurora Family Counseling Center

INFORMED CONSENT AGREEMENT

Nature and Course of Treatment: Therapy is a collaborative effort between the client and the therapist. During the initial evaluation period, the client and therapist will work together to the clarity of the primary treatment issues and to develop a treatment plan. The treatment plan may include attending support groups or accessing other community resources, reading selected materials, completing specific written or verbal assignments and/or getting a medical evaluation. Throughout the course of therapy, the client is expected to follow the treatment plan, attend sessions regularly, and to abstain from all non-prescription mood-altering substances. The course of therapy will depend upon the selected treatment goals and duration will be decided collaborative between the client and the therapist.

Risks and Benefits of Participation: Therapy is designed to be helpful and to effect positive changes; however, during the course of treatment the client may experience discomfort or other negative feelings. If this should occur, the client is encouraged to discuss these feelings with the therapist so that the client and therapist can work through these feelings together.

Confidentiality: All information disclosed by an adult client to the therapist will be kept confidential unless: 1) the client provides a written authorization to the therapist to release information to a specific party; 2) the client presents a danger to self or others; or 3) if child, elder or dependent adult abuse is suspected, the therapist is required to take steps to prevent harm; this includes breaching confidentiality by notifying authorities. Client will be informed when confidentiality is breached unless extenuating circumstances exist.

Release of Information to a Health Plan: If the client is participating in a Health Plan,certain information may be required for reimbursement. This information may include: diagnosis, expected course of treatment and treatment goals. If the client has many questions or concerns regarding specific information transmitted to a Health Plan, the client should discuss this with the therapist. The client will receive a copy of "Notice of Privacy Practices" as defined by the Health Insurance Portability and Accountability Act (HIPPA) regulations of 1996, effective since April 14, 2003. Aurora Family Counseling Center and all therapists employed by the agency strictly adhere to HIPAA.

Treatment of a Minor and Families: While parent/legal guardians have the legal right to information regarding their child's (anyone under the age of 18) treatment, it is recommended that certain aspects of the therapist-client communication remain confidential in order to enhance the therapeutic effectiveness. However this will be collaboratively determined between the minor, their parent(s)/legal guardians and the therapist. Parent(s)/legal guardians will be informed if a minor poses a danger to self or others. Furthermore parent(s)/legal guardians are strongly encouraged to participate in the therapeutic process by ensuring attendance by the minor, presenting therapy as a positive experience, and by adhering to the mutually agreed upon confidentiality guideline. If a family is in treatment, limits of confidentially will be established collaboratively except when report laws of child abuse, elder or dependent adult abuse, danger to self or others, or treatment emergency laws apply.

Emergencies: If the client is in imminent danger (to self, others, or from someone else), the client should call 911 or the nearest police department or emergency room. If a client is in a treatment crisis and needs to reach a therapist during non-business hours, the client should call the main agency phone number and an "emergency" number will be provided on the answering machine. However, the client should make all possible reasonable efforts to utilize healthy coping skills in order to keep themselves and others safe and to address the matter in the next therapy session. For non-critical matters (such as canceling and/ or rescheduling an appointment) a message may be left for the therapist through the main agency phone number.

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Financial Terms: Upon verification of health plan/insurance coverage and policy limits, Aurora Family Counseling Center, Inc. will bill the health plan for services rendered. Verification/authorization received does not guarantee payment. The client will be responsible for any applicable deductibles, co-payments, and fees that are not reimbursed by the health plan. Co-payments are expected to be paid at the time services are rendered and may change without notice. If the client is not covered by a health plan at the time that services are rendered, the client is responsible for payment of all charges. If the client does not plan to use health plan benefits ("cash pay" client), payment arrangements should be made prior to the first appointment. Aurora Family Counseling Center, Inc. reserves the right to request the entire fee for service from the client and to provide the client with a "super bill" for submittal to the health plan for reimbursement. Group therapy is generally not a covered benefit with most health plans/insurance companies.

A $30.00 fee for each NSF check plus the amount owed for the service(s) will be due and payable prior to the next scheduled visit in cash or money order/cashier's check.

When there is a need for a written report, you will be billed at a rate of $50.00 per page.

Cancellations and Missed Appointments: The client is expected to attend each scheduled session. If the client plans to miss a session, the client is expected t ogive at least 24 hours notice. If an appointment is missed or canceled with less than 24 hours notice, the client may be required to pay a $50.00 rescheduling fee. Frequent cancellations and/or missed appointments may result in the termination of treatment.

Appeals and Grievances: The client has the right to request reconsideration ("appeal") in the case that outpatient care (number of sessions) is not authorized. The client can request an appeal through the health plan, at no risk to the client. If the client has a complaint (grievances) at any time about any aspect of treatment, the client has the right to submit a grievance directly to the client's health plan or Aurora Family Counseling Center. However, the client is encouraged to first approach the therapist with concerns.

Consent: By signing this form, the client acknowledges that he/she understands the nature and course of treatment, the risks and benefits of participating in therapy, exceptions to the confidentiality, emergency procedures, scheduling arrangements, standard of care issues, that he/she accepts the financial terms. The client also acknowledges that he/she is entitled to ask questions and receive answers regarding this consent form. The client may request and receive a copy of this form.

Client/Parent/Legal Guardian:

_____
Print Name

_____
Signature

_____
Date

Client/Parent/Legal Guardian:

_____
Print Name

_____
Signature

_____
Date

PROVIDER: _____ _____ _____
Print Name Signature Date