**Rebecca H Radcliffe Counseling**

**Informed Consent to Treatment**

**Client Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Preferred Phone** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Ema**il\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance Benefits and Payment Information:** I am an in-net-work provider for certain insurance companies, but not all. You must inform me prior to services and present your insurance information in order to utilize your insurance for service. You cannot submit for insurance reimbursement for dates of service prior us being aware of your participation. If you have secondary insurance that I am not paneled with you may not be able to use any of your in-network benefits. As a client you give permission for therapist to relay certain required information to your insurance carrier for billing and authorization purposes. You also agree to pay the insurance contracted rate for service. Any funds received from insurance companies above my contracted fee will be refunded to me when my account is paid in full. I understand that my private health information is confidential. Fee structures for all legal matters are available upon request and are not covered under typical hourly or insurance reimbursable rates. I understand that more information is available through my therapist. I acknowledge that I received information about my HIPAA rights and that I am free to view these rights at any time at [http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html)

For out-of-network benefits I will bill your insurance directly when possible or provide a superbill upon request so that you may submit for reimbursement that would go to you directly. Insurance companies rarely, but occasionally, require additional information and steps that we would not be able to comply with. This may lead to your reimbursement claims being denied. Payment for services always remains your responsibility.

**Based on an initial insurance benefits check, you have a deductible of \_\_\_\_\_\_\_\_ and a copay/coinsurance of \_\_\_\_\_\_\_\_ per session. Once your deductible is met, your copay/coinsurance may change. Note:** You agree to pay this in full at time of each session. Payment can be collected using cash, check or credit card. If you would like to have recurring payments set up through your credit card, please fill out the following information below. You can change it at any time and are requested to inform us of any changes to payment methods. You are responsible for keeping sufficient funds in the account provided and informing us in a timely manner of any changes to credit cards on file. You understand that you are still responsible for any charges that are not covered by your insurance. All payments for copays, deductibles, missed appointments and other legitimate fees (letters written, paperwork, court costs etc) will be billed automatically and recorded through Therayappointment.com. This site is secured and encrypted.

**Name as it appears on card**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Billing address of card**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Credit Card or HSA #** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Exp. date**\_\_\_\_\_\_\_ **Security #** \_\_\_

**SELF PAY/SLIDING SCALE RATE:**

\_\_\_\_ Initial here if you do not have insurance or are self-selecting to be a self-pay and not go through your insurance. You acknowledge that you will pay out of pocket at the established rate and that you will not seek later reimbursement directly through the insurance company or have therapist submit claims on your behalf. This agreement may be canceled, in writing, at any time for dates forward of the dated and signed cancellation.

\_\_\_\_\_\_\_ (Initial) Y**ou agree to a self-pay rate of \_\_\_\_\_\_\_\_ for the intake session and \_\_\_\_\_\_\_\_for each session afterwards.**

**Scheduling and Communication:** Please go to therapyappointment.com to select your therapist “Rebecca H Radcliffe” and send encrypted email or to make or change any appointments. You can also call, email or text your therapist directly for scheduling purposes. However, by reading this clause you acknowledge that texting and unsecured email is not confidential and therefore discouraged beyond a quick note if you are running late or other simple scheduling concerns.

**E-mail/Social Media Policy:** Although email through Therapyappointment.com is encrypted, we do not encourage extensive clinical communication through email but you do so at your own risk. We will not respond to requests to communicate through any personal social media sites such as Facebook, Twitter or Linkedin.

**In Case Of Emergency:** I am available for crisis management by phone at 610-937-2207. In the event that I am not able to respond to your phone call in a timely manner, please go to the nearest emergency room, call 911 or call the following mobile crisis numbers. Baltimore County Mobile Crisis at 410-931-2214 or National Suicide Hotline at 1-800-273-8255

**\_\_\_\_\_\_\_** I also acknowledge that I have received by therapist a Crisis Emergency Policy and Resource sheet

**Cancellation policy:** All appointments must be canceled with 24 hours advance notice to avoid the late cancellation/no show fee. **Cancellation fee is $25 for the first no show or late cancellation and $50 for each no show or late cancellation subsequently**. I will waive the fee once per calendar year in the event of an emergency. I will charge the credit card on file for these no show/cancellation fees or require payment before attending next session if credit card info is not on file or declined. Sessions are often scheduled back to back, so it is important to arrive on time. If your therapist is running late, you are entitled to your full 45 minute session. If you are running late, your therapist will not cut into the next scheduled appointment time. If you are more than 10 minutes late, you will be charged the full cancellation fee because we cannot bill insurance if we meet for less than a 37 minute session.

**Confidentiality:** I understand that my therapist, in keeping with standard medical practice and Maryland Code of Ethics, is bound by confidentiality. All information that you share about yourself will be kept confidential except for the following legal exceptions:

* If my therapist needs to consult about my case in supervision or group consultation using non-identifying anonymous information for the purpose of providing the most beneficial treatment possible.
* If there is reasonable suspicion that a child or vulnerable adult/elder is currently being abused or neglected
* If you are a clear and imminent risk and danger to yourself or others
* If there is a court order
* If you provide written consent and sign a release of information allowing communication to occur between third parties

If we run into you in public, in person, or online, we will not acknowledge you first in order to protect your confidentiality.

If any portion of this contract is rendered void for any reason, the other portions of the contract shall remain in force.

**My signature below signifies that I have read, acknowledged and agreed to everything in this contract:**

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Signature of responsible party Date