Name______________________________ DOB ______________

Authorization for Consent for Treatment and Acknowledgements

<u>CONSENT FOR TREATMENT</u>: I consent to treatment and agree to abide by the policies and agreements with the Associated Clinic of Psychology (ACP), as stated herein.
<u>CONSENT FOR MINORS:</u> A guardian(s) must give consent for treatment of a minor. The clinic requires copies of court documents related to custody and guardianship in order to validate consent.

<u>ACKNOWLEDGEMENTS</u>

- **CLIENT RIGHTS AND DATA PRIVACY**: I have received a copy of the document "Client Rights and Data Privacy" and a copy of the "HIPAA Notice of Privacy Practices" pamphlet.

- **FINANCIAL AGREEMENT:** I agree that in return for the services provided to me, I will pay my account at the time that service is rendered. If co-payments and/or other deductibles are a part of my insurance health plan, I agree to pay them at the time of service. I agree to pay all charges not covered by insurance. I understand and agree if my account is delinquent, I may be charged interest at the legal rate. If my account is sent to an attorney for collection, I agree to pay all collection expenses and reasonable attorney's fees as established by the court and not by jury in any court action.

- **ASSIGNMENT OF INSURANCE BENEFITS**: I authorize benefits of any type under my insurance plan or any party liable to me is hereby assigned to the Associated Clinic of Psychology. I authorize the Associated Clinic of Psychology to release health records to insurance carriers for purposes of processing claims for services rendered to me.

- **CANCELLATIONS:** I understand that I need to give at least a 24-hour notice when cancelling or rescheduling a scheduled appointment. If I fail to do so, I will be subject to a charge of $50.00 for the appointment, subject to the provider's discretion. ***ACP reserves the right to restrict scheduling due to no shows or cancellations.***

- **COURT COSTS:** I understand that if a clinician or other member of the Associated Clinic of Psychology is required, by subpoena or other means of summoning, to appear in court on my behalf that I will be responsible for a fee for all time and costs associated, including but not limited to deposition time, attorney meetings and calls, travel time, preparation time, research, costs for copying records, time in court, etc. Therapy: $250/hour. Psychiatry: $500/hour.

- **CLINIC RIGHTS:** I understand that any verbal or physical aggression towards any person working for ACP or clients receiving services at ACP will be grounds for immediate termination of services.

By signing below, I consent to treatment and understand and agree to the policies and terms outlined above. This document is subject to regular updates.

Client Signature: ____

Printed Name:______________________________ Date: ______________

Parent/Guardian Signature:__________________________Date:______________

Relationship to client:____

If Client is unable to sign, reason: ______________________________________