ACP ASSOCIATED CLINIC OF PSYCHOLOGY

Authorization for Consent for Treatment and Acknowledgements

Client Name ____ DOB _____________________

CONSENT FOR TREATMENT: I consent to treatment and agree to abide by the policies and agreements with the Associated Clinic of Psychology (ACP), as stated herein.

CONSENT FOR MINORS: A guardian(s) must give consent for treatment of a minor. ACP requires copies of court documents related to custody and guardianship in order to validate consent.

ACKNOWLEDGEMENTS

- **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 $120.00 (or higher for psychological testing). 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. Psychological Testing: $350/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.

- **TELEHEALTH POLICY:** I have received a copy and understand ACP's Telehealth Policy and Procedure.

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ASSOCIATED CLINIC OF PSYCHOLOGY

- **AUTHORIZATION FOR COMMUNICATIONS VIA TEXT OR EMAIL AND ACKNOWLEDGMENT:** Per HIPAA regulations you have the right to receive communications via text message and/or non-secured email from ACP, if you choose. These messages will be used for scheduling, logistics, and administrative purposes only. ACP clinicians will not provide any services or other communications via text or email. Any protected health information (PHI) sent by ACP will be sent securely by alternative means or encrypted email. Before considering using non-secured email or text communication be advised that text messaging and nonsecure email messaging is an unencrypted conversation that has the potential to be read by a third party. Your cell service carrier rates will apply to communications via your cell phone. ACP is not responsible for any charges you may incur.

- **SUPERVISION PROGRAM**: I understand that at times my provider may be under the clinical supervision of another clinical provider based on licensing requirements or credentialing requirements. Your visit may be billed to your insurance under this Clinical Supervisor.

- **ACP SHADOWING PROGRAM**: I understand that occasionally there may be another provider or clinical student intern shadowing my group or individual session as part of their learning process. My provider will discuss this with me if this situation arises and I am always able to decline to have another provider/student shadow these sessions.

- **EMERGENCY CONTACT:** In case of emergency, ACP is authorized to contact the following person for the purpose of assessing client safety or whereabouts or obtaining other emergency information. Clinical information will not be released unless necessary to confirm or assess safety.

  Emergency Contact Name: ____

  Phone Number: ______________________ Relationship: ______________________

- **INSURANCE INFORMATION (only needed for Community-Based Services):**

  Insurance Company: ______________________ Member/Policy ID: ______________________

  Group #:____________ Policy Holder Name & Relationship to Client: ______________________

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: ____ Date: ________________

Printed Name: ____

Parent/Guardian Signature: ________________________________ Date: ________________

Relationship to client: ____

If Client is unable to sign, reason: ____