Comprehensive Psychiatry Group, Inc.

TREATMENT CONSENT

A. Mental Health or Substance Use Counseling is a process by which people improve and change how they feel, act, or think by talking to someone. Sharing feelings about the past and about the present might be difficult. You or your child may even feel worse before things improve. In addition, you may be asked to change the things you do to improve the situation. For instance, if parents alter their responses to their child's problematic behaviors, the child may be helped greatly with his / her problems.

B. During your first session we will want to know your concerns, the history of your concerns, and how you have been dealing with them. We will ask about past events in your and your family's life. Additional information may be gained through more interviewing or testing, and this well be discussed with you at that time. After we understand your concerns we will develop a treatment plan to work with you and schedule sessions accordingly.

C. Issues discussed during the course of therapy with a therapist or physician is confidential; the information you reveal will not be discussed without a signed release from you. Nonetheless, there are unusual circumstances that are exceptions to confidentiality; in situations of potential harm to oneself (suicide), or others (homicide), or suspected child abuse or neglect, and in instances where the court may subpoena records (most commonly contested divorce actions). The release of confidential materials is, or may be, required by your counselor. You or your counselor may request that some information be discussed with another person by signing a release form.

I understand and agree to the following:

1. I will be actively involved in the counseling process, including the development of the treatment plan, and I will practice at home what is discussed in sessions.
2. I will pay for sessions that I do not cancel with a minimum of a 24-hour advance notice. (Insurance companies are not responsible for this charge). This applies to all situations unless emergency medical care is required. If I have a concern about this, I will discuss it further with my therapist / psychiatrist.
3. If more than ninety - (90) days lapse without payment to Comprehensive Psychiatry Group, CPG reserves the right to turn my account over to a collection agency or credit reporting service.
4. If I am unsatisfied with the services provided or if I have any complaints, I will be encouraged to discuss this with my Therapist / Nurse / Psychiatrist. If my concern is not addressed to my satisfaction, then I may contact the Grievance Officer.
5. If I have any questions about the nature of my counseling (i.e. goals, procedures, etc.) fees, or any other issue, I need to ask. I am encouraged to bring up such matters for discussion since they are an important part of my treatment.
6. I hereby commit to provide Comprehensive Psychiatry Group with current and timely insurance information. This includes any secondary or tertiary coverage as applicable. If I fail to provide Comprehensive Psychiatry Group with current & complete insurance information and it results in denial of payment, I understand that I will be held responsible for any unpaid balance. Failure to repay that balance in a timely manner or refusal to pay may result in termination of services at CPG.
7. According to Rule 5122:2-1-02 of the Ohio Revised Code, I have the right to refuse treatment or withdrawal from any or all of the specific modalities of treatment provided.

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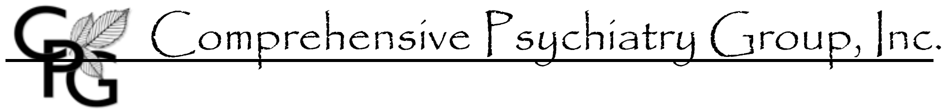
Patient Date   Parent / Guardian (if applicable) Date



TREATMENT CONSENT

TREATMENT REVOCATION

In keeping with my rights, I refuse treatment or withdrawal from any part, or all of the treatment being provided (describe modality of treatment): ___________________________
I also understand that in doing so, staff will work with me to develop alternative approaches to ensure that I receive the services I need.

SIGN BELOW ONLY TO REVOKE YOUR CONSENT

_________________________________ _________________________________

Patient Date Parent / Guardian (if applicable) Date

BILLING AUTHORIZATION

Comprehensive Psychiatry Group Benefit Verification staff makes every effort to obtain accurate information about my insurance benefits and the extent of my mental health / behavioral health coverage. While they attempt to follow my carrier's guidelines in obtaining this information, they cannot guarantee the accuracy of the coverage as stated to them by my insurance carrier. It is ultimately my responsibility to check on my benefits and to determine the extent of my coverage.

RELEASE OF INFORMATION

CONSENT TO RELEASE INFORMATION FOR BILLING PURPOSES: I hereby give Comprehensive Psychiatry Group permission to release information regarding my care to my insurance company, health benefit plan, employer (if work related), or other third party payer, including Medicare and Medicaid that is reasonably necessary to pay claims, determine eligibility and receive payment for the services I receive.
ASSIGNMENT OF BENEFITS: I hereby request that any payments under the terms of my insurance, health benefit plan, or from other third party payer, including Medicare and Medicaid be made directly to Comprehensive Psychiatry Group. This includes all monies payable on my behalf or payable to me under the terms of such plans or entitlements, but not to exceed customary or regular charges for the services I receive.
RESPONSIBILITY FOR PAYMENT: I understand that regardless of any insurance or other health benefits I may have, I am responsible for any applicable co-payments or deductibles and for any amounts not covered or reimbursed by such programs.

_________________________________ _________________________________

Signature Date Relationship to the Patient