Agreement Regarding Consent to Treatment, Polices, Services & Fees

The following is a statement of your Consent to Treatment and our Financial Policy, which you are required to read and sign prior to any treatment.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE. I accept payment through PayPal and Square.

Regarding Insurance:

Please keep in mind that I do not accept insurance. You are responsible for paying all fees. I can, upon request provide you with a detailed invoice every month that you can submit to your insurance company for reimbursement.

Confidentiality:

Information regarding your treatment is confidential and will not be released without your written consent.
Information regarding your minor child will not be released without your written permission.

Certain exceptions to these rules exist:

- If I have reasonable cause to believe (i.e., reasonable suspicion or evidence) based on patient's communication that a child under the age of 18 is suffering physical or emotional injury resulting from abuse, inflicted up on him or her which causes harm or substantial risk of harm to the child's health or welfare (including sexual abuse), or from neglect (including malnutrition), the law requires that I file a report with the appropriate social service (Child Protective Services) and legal authorities. In addition, if a patient reports that he/she was physically or sexually abused as a child, or engaged in sexual acts with an adult while a child, and the reported perpetrator currently has access to children, the law requires that I file a report with the appropriate social service (Child Protective Services) and legal authorities.
- If I have reason to believe an elderly or handicapped individual is suffering from abuse or maltreatment, the law requires that I file a report with a law agency and/or the State Department of Social Services.
- If a patient communicates an immediate threat (i.e., with clear intentionality of harm or a plan to harm) of serious physical harm to an identifiable victim, I may be required to take protective actions. These actions may include notifying the potential victim, contacting the police, and/or seeking hospitalization for the patient.
- If a patient threatens to harm himself/herself (i.e., communicates intent and/or a plan for suicide), I am required to notify legal authorities and make reasonable attempts to notify the patient's family members or others who can help provide protection.
- If you are required to sign a release for psychotherapy records if you are involved in litigation or other matters with private or public agencies.

It is also important to be aware of potential limits to confidentiality that include the following:

- All records as well as notes on sessions and phone calls can be subject to court subpoena under certain extreme circumstances.
- Most records are stored in locked files but some are stored in secured electronic devices.
- Cell phones, portable phones, faxes, and e-mails are used on some occasions: note that all electronic communication compromises your confidentiality.

Other situations in which patient confidentiality may be compromised without the patient's consent or authorization include the following:

- If a government agency is requesting the information for health oversight activities, I may be required to provide it for them.
- If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding the patient in order to defend myself.

Treatment:

Each client will receive specific, complete and accurate information regarding the treatment that they receive. This information will be in both written and verbal form. You are free to withdraw consent at anytime and to terminate your treatment.

Treatment Alternatives:

There are multiple alternatives to outpatient behavioral health treatment, including (but not limited to): bilbotherapy (reading books), religious care, community support, holistic healing, alternative medicines such as acupuncture or energy healing, nutritional healing, and aromatherapy.

Possible Outcomes, Benefits and Side Effects:

The overall goal of behavioral health treatment include (but are not limited to) improvement in mental health, physical health, family functioning, improvements in all relationships, social functioning, employment functioning, resolutions of legal distress and/or reduction of substance use concerns.

As clients participate in outpatient treatment, many difficult and stressful issues might be addressed. Therefore, at times, side effects of treatment might include a temporary increase in negative symptoms. I encourage you to discuss this with me in treatment as these issues arise.

Emergencies:

You may reach writer by leaving a voice mail if I am unable to take your call. Should an emergency arise and I am not available please contact 911.

Cancellations and Changes of Your Appointment Time:
Unless cancelled, at least 24 hours in advance, my policy is to charge for missed appointments at the rate of a normal office visit.

Client's Responsibilities:
The Client is responsible for all charges.

Statement of Agreement:
Thank you for understanding our Consent to Treatment Financial Policy. Please let us know if you have questions or concerns.

_____ _____

Client/Responsible Party Signature Date

HIPAA CONSENT

I, _____, have read and received a copy of this office's HIPPA PRIVACY NOTICE.

My signature here certifies my consent that I may use/share your Protected Health Information as described in the HIPAA PRIVACTY NOTICE you have received. Please make sure to read that document and ask us any questions.

After you have signed this consent, you have the right to revoke it (by writing a letter to Dr. Schwellinger). We will then comply with your wishes from that time forward. Of course we cannot do anything about information shared previous to your revocation.

_____ _____

Client/Responsible Party Signature Date

_____ _____

Psychologist's Signature Date