

CONSENT FOR TREATMENT

This contract explains the conditions that you, as the client, have agreed upon when obtaining services through Center for Psychological Wellness, Inc. (hereafter referred to as CPWI). Some of these rights and obligations are imposed by Florida law while others are established herein by contractual agreement. Any concerns regarding the matters stated herein should be discussed prior to initiation of treatment. Your signature at the end signifies your consent in its entirety.

CPWI is authorized to use the contact information outlined below for appointment reminder calls and written correspondence. Additionally, I understand that I will be required to provide written notification if I desire to change or revoke consent.

Name: _____ Date of Birth: ___ / ___ / ___ SS#: _____
Address: _____ Home Phone: _____
_____ Other Phone: _____

It is acceptable NOT acceptable for a CPWI representative to leave a message with someone or on a voicemail at the number(s) listed above.

EMERGENCY CONTACT:

Name: _____ Phone Number: _____

CONFIDENTIALITY

Please see the *Notice of Privacy Practices* posted in the office waiting area or request a personal copy at the front desk.

CHILD AND ADOLESCENT

In the case where the identified client is a minor, authorization is granted by a legal guardian for the provision of diagnostic and therapeutic services by CPWI. Further, the involvement of the significant individuals in a child's life is frequently necessary for positive change. The guardian(s) agree to participate in treatment and assist in getting other significant individuals in the child's life to participate as well.

FAMILY, GROUP AND COUPLE THERAPY

Unless otherwise specified, when multiple individuals with a common bond or relationship are seen in therapy, the "client" is the relationship that binds the individuals together (i.e., the marriage in marital therapy). CPWI does not take responsibility in any instance where confidentiality may be breached by one of the participants. Further, individual therapy for any of the participants is available by referral.

ACCESSIBILITY

Each CPWI associate tries to be available to clients by telephone for any emergencies that may arise. If an emergency arises at any time, the client or guardian should call CPWI'S office to reach the therapist (or covering peer in situations of illness or vacation) immediately. CPWI is equipped with a voice messaging system so that each therapist is accessible at all hours to assist with crisis situations. Telephone consultations/sessions

REASONABLE EXPECTATIONS

The client's therapist will execute his/her professional knowledge and skills in every effort to assist in obtaining the client's specific objectives. In some instances, clients may experience a slight decline prior to experiencing improvement. As therapeutic services are individual in nature, CPWI can make no guarantees to the outcome of services.

COORDINATION OF CARE WITH PRIMARY CARE PHYSICIAN

I hereby authorize CPWI: To release applicable information to my Primary Care Physician:
Name: _____ Phone: _____ Fax: _____

NOT to release information to my Primary Care Physician.

I understand that my records are protected under the applicable state law governing healthcare information that relates to mental health services and under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records 42 DRF Part 2, and cannot be disclosed without my written consent unless otherwise provided for in state or federal regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. This release will automatically expire twelve (12) months from the date signed.

CLIENT OR GUARDIAN SIGNATURE

PRINTED NAME

DATE

WITNESS SIGNATURE

PRINTED NAME

DATE

FINANCIAL CONDITIONS

Our office policy is to charge usual and customary fees for therapeutic and psycho-educational services provided. The client, or responsible party (if client is a minor) is ultimately responsible for the fee at the time that services are rendered. This fee may be adjusted in the following circumstances:

A special rate has been negotiated with a third-party payor (i.e., insurance company, HMO, PPO);

*No or very limited insurance coverage exists; or

*Existing coverage has been exhausted.

*In these cases, a rate is negotiated on a "sliding scale" based on verifiable financial hardship.

APPOINTMENT SCHEDULING AND CANCELLATIONS

If the client or responsible party has reserved an appointment and chooses for any reason not to utilize that time, twenty-four (24) hours notice is required. This allows CPWI sufficient time to offer the time slot to another client who may be awaiting an opening. If inadequate notice is given or a client misses an appointment that he or she has reserved, the client or responsible party will be held financially liable for the reserved appointment. This fee will be based on the contracted rate per session, NOT the co-payment. The office cannot provide assurance that a reminder call will be made prior to each appointment.

PHONE CALLS BETWEEN SCHEDULED APPOINTMENTS

Therapists are available for telephone consultation if/when an emergency issue may arise prior to the next scheduled appointment. Fees related to such calls will be charged directly to the guarantor (NOT the insurance company) and will be charged as follows:

Calls up to 15 minutes in length: \$25

Calls between 15 and 30 minutes: \$50

Calls beyond 30 minutes: An additional \$10 per 5-minute interval

Situations requiring multiple calls will be billed based on the aforementioned fee structure at the therapist's discretion.

LETTERS, FORMS AND MISCELLANEOUS PAPERWORK

All written correspondence requested or required to be completed will be charged based on the therapist's hourly appointment rate.

DELINQUENT OR INSUFFICIENT PAYMENT

Payment is expected to occur at the time that services are rendered. Any returned check fees will be forward to the guarantor and will be charged at a minimum rate of \$25 per occurrence. If an outstanding guarantor balance should develop, sessions will be interrupted until said balance is rectified.

Having discussed your financial situation and terms, we both agree to the terms above and the following fee arrangements:

Private pay fee of \$ _____ per session. OR Insurance plus co-payment of \$ _____ per session.*

(If applicable) Payments toward deductible: \$ _____ per session for first _____ sessions.

*While CPWI will assist in determining the limits of insurance coverage, the client or responsible party is expected to understand his/her own insurance coverage and required to guarantee payment for services utilized.

***SIGNATURE ON FILE:**

I authorize the release of any payment and clinical information necessary to process claims made on my behalf or that of my family member. Please accept a photocopy of this authorization as if it were an original. My signature below acts as a signature on file.

Signature: _____

Date: _____

***ASSIGNMENT OF BENEFITS:**

I hereby authorize direct payment of insurance benefits to CPWI for professional services rendered. I understand that I am financially responsible for all charges not covered by this assignment.

Signature: _____

Date: _____

I acknowledge that I have reviewed and understand the terms of the contract and do hereby consent to treatment under these terms. In case of a minor client, I acknowledge that I am the legal custodian and can legally consent to treatment, should legal custody change following the onset of treatment, I agree to notify CPWI immediately.

CLIENT OR GUARDIAN SIGNATURE

PRINTED NAME

DATE

WITNESS SIGNATURE

PRINTED NAME

DATE

INITIAL INTAKE QUESTIONNAIRE & ASSESSMENT

CLIENT'S NAME: _____ AGE: _____ TODAY'S DATE: _____

The information provided below will be used by your therapist and maintained as part of the clinical record. Please review the following list for symptoms that you may have experienced in recent days or weeks and check all the apply:

IF COMPLETED BY PARENT/GUARDIAN, PLEASE PROVIDE NAME & RELATION: _____

- | | | | | |
|---------------------------|-------------------------------|-----------------------|-----------------------|--------------------|
| Crying spells | Change in sleep | Family problems | Angry outbursts | Change in appetite |
| Relationship problems | Increased nervousness | Eating changes | Social problems | Sadness |
| Headaches | Work/school problems | Trouble concentrating | Suicidal thoughts | Lonely |
| Change in sexual activity | Suicidal thoughts | Feel out of control | Homicidal thoughts | Seeing things |
| Loss of trust in others | Financial problems | Panic Attacks | Drastic weight change | Hearing things |
| Forgetfulness | Violent feelings | Increased drug use | Increased alcohol use | Confusion |
| Other physical complaints | Other (please specify): _____ | | | |

Please briefly describe the reason for which you are coming today:

Have you previously received counseling or psychological services? No Yes

Date(s): _____ Provider(s): _____

Outcome: _____

Do you have any medical conditions? _____

Primary Care Physician: _____ Phone #: () _____

Current Medications: No Yes: _____ Known allergies: _____

Prescribing physician: _____ Phone #: () _____

THERAPIST ASSESSMENT NOTES

DIAGNOSTIC IMPRESSION: _____ RECOMMENDATIONS: _____