Poyner Psychological Services 14453 SE 29th Suite D, Choctaw, OK 73020 405-741-2844

CLIENT NAME:	AGE:	HOME PHONE:
ADDRESS:	DOB:	CELL PHONE:
PARENT NAME: (IF CHILD CLIENT)	Emergency #	WORK PHONE:

CONSENT FOR TREATMENT/SERVICES

PROFESSIONAL DISCLOSURE STATEMENT: Welcome to this practice. Please read this document carefully as it contains important information about our services and policies. When you sign this document it will represent an agreement between you and your clinician. We are trained in and provide psychological services in the form of testing, therapy, forensic services, crisis intervention and referrals to more acute care. We have Licensed Psychologists, Licensed Professional Counselors, as well as Post-doctoral Residents who are under supervision and completing licensure requirements. Our Licensed Psychologists and Post-doctoral Residents are governed by the Oklahoma State Board of Psychology Examiners. Should you have any concerns about their services, you can reach the Board at 405-524-9094. Our Licensed Professional Counselors are governed by the Oklahoma State Department of Health Division of Professional Counselors. They can be reached at 271-6030. Our Licensed Drug and Alcohol Counselors are governed by the Department of Oklahoma Mental Health and Substance Abuse services. They can be reached at 405-840-8908.

IMPORTANT: **Children (under the age of 13) CANNOT be left unattended in the waiting room and must be supervised by an adult at all times. It is the parent/guardian's responsibility to provide that supervision and we assume no responsibility for an unaccompanied child's safety**. Please initial here: ___________

PSYCHOLOGICAL SERVICES: There are many methods your clinician may use to help you with your problems. Therapy calls for an active effort and so you will be expected to work during sessions and also between sessions. Psychotherapy has benefits and risks. Talking about distressing topics may cause you to experience uncomfortable feelings like sadness, guilt, anger, frustration and loneliness. However, therapy has also been shown to have benefits for people who participate in it. Therapy often leads to better relationships, solutions to specific problems, and reductions in feelings of distress. However there are no guarantees about what you will experience and it is possible that symptoms may not improve. Your clinician will evaluate your needs, talk about what your work will include and work with you to develop goals and a treatment plan. If decide to continue with therapy you should be comfortable working with your clinician. If at any time you are uncomfortable with your clinician, please talk with him or her. If your discomfort persists, we will be happy to refer you to another practitioner. You are free to stop therapy at any time.

FEES FOR SERVICES: Therapy sessions typically last between 45 and 50 minutes and are usually scheduled once a week or more often if needed. **You will be expected to pay for each session (total fee or copay) at the time of the appointment. If two or more fees are not paid, your therapist may visit with you about receiving services elsewhere**. Please initial here: ________ If you have insurance coverage it is your responsibility to obtain pre-approval for services. It is your responsibility to find out exactly what your insurance does and does not cover. If you have any questions you should call your plan administrator. **We will bill your insurance; however, you are ultimately financially responsible for paying for the services you receive**. Please initial here: __________

Services include, among others, therapy, play therapy, family therapy, testing, report writing, consultation with other professionals, preparation of treatment records or treatment summaries, phone calls and meetings with other professionals (contingent upon a signed release of confidentiality). Note: insurance companies typically reimburse only for intakes, therapy and (sometimes) testing. They do not pay for marital therapy. The fee for an intake is $175.00, and hourly services (including therapy) are $120.00 per hour (or as contracted with insurance companies). **We charge a $30.00 return check fee and a $50.00 fee if you no-show for your appointment or cancel with less than 24 hours notice.** Please initial here: _________. If you require that records be sent to another person, the charge for this service is between $15 and $30 depending on the size of the file and must be paid prior to that service.

Legal proceedings that require any participation by our clinicians are reimbursed at a rate of $250.00 an hour—even if called to testify by another party. Forensic services are not covered by insurance and require a separate consent form. If we are required to fill out forms or write letters for outside agencies, we will charge a minimum of $50.00 for this service. You should be aware that most insurance companies require you to authorize us to provide them with a diagnosis and sometimes other clinical information such as treatment plans or, in rare cases, a copy of your file. This information will become part of the insurance company's files and we have no control over its confidentiality once it has left our office. If your account has not been paid for more than 60 days and payment arrangements have not been agreed upon, we have the option of using legal means to secure payment. This may involve hiring a collection agency or going through small claims court. We also reserve the right to charge interest on delinquent accounts (more than 60 days overdue), as well as collect all costs of securing payment from you. In most collection situations the only information we release is the patient's name, address and telephone number, as well as the amount due and the nature of the services provided.

CONTACTING US: We are often not immediately available by telephone. While we are usually in the office between 8 and 5 M-Th, we may not always be able to answer the phone. We are closed on Friday unless you have a special arrangement. When we are with a client or away from the office the phone will typically be answered by office staff or a message machine. Please leave a message and we will make every effort to contact you as soon as possible. If there is an emergency and you can't reach us, please call 911 or go to the nearest emergency room. You can also call the Oklahoma County Crisis Center at 405-522-8100.

RECORDS: The laws and standards of our profession require that we share with you your records unless we believe that could be emotionally damaging. However, we with a signed release we will be happy to send your records to a mental health professional of your choice. If the client is under the age of 18 the law provides parents access to their records.

SUBSTANCE USE: We request that you be free of alcohol or other intoxicants prior to coming in for therapy. If we believe, however, that your senses are impaired we reserve the right to call a friend, family member or taxi to drive you safely home. In that case we will ask for your car keys to insure your safety and that of authors. Should this become an issue we reserve the right to call authorities.

LEGAL ISSUES: Legal matters are very hard on everyone involved but especially for children. So that children can be treated in a safe environment we ask that you agree that we will not be called to be a witness in any litigation involving your child. However, a judge may not honor this agreement and may mandate access to records or an appearance in court to provide testimony. We will make no recommendations regarding visitation or custody issues for children being seen for therapy. By signing this consent to treatment, you are agreeing to this policy. If a parent believes that a child should be evaluated for issues related to a legal issue, or if a custody evaluation is court ordered, we will be happy to refer them to a forensic psychologist. **If a child is receiving therapy services at this office, we will NOT participate in any legal activity (unless court ordered) that requires talking with an attorney, providing records that may be used in a parental dispute, testifying in court, or in any way becoming involved in divorce, child custody, visitation or any other legally-related issue**. Please initial here: ________

CONFIDENTIALITY: As part of the intake process we will give you a notice of THE PSYCHOLOGIST'S POLICY AND PRACTICES TO PROTECT THE PRIVACY OF YOUR HEALTH INFORMATION. This HIPPA document is very important for you to read and understand. In general, the privacy of all communication between a client and a psychologist is protected by law and we can only release information with your written permission. Indeed, records and information that involve mental health or substance abuse services are confidential and privileged. However, current laws permit or require the release or disclosure of such confidential information under certain circumstances:

1. Information may be released with a patient's or legal guardian's written consent. Release may be ordered by a court, or may be subject to release in the case of legal action related to the records or to a patient's physical, mental or emotional condition.
2. Notification of state authorities is required by law if we have reason to suspect child neglect or abuse, or we suspect the abuse, neglect or exploitation of an elderly or incapacitated adult. Also, if a client indicates that he or she may present a danger to self or others we may breach confidentiality to try to ensure the safety of anyone involved, such as notifying a family member or the person at risk, calling the police, or arranging for the patient's hospitalization.
3. Information may be released if necessary to collect fees owed for professional services, provided that the only information relevant to the financial resolution may be disclosed. In addition, we may release information necessary to respond to any legal proceedings or any complaints with a licensing board or regulatory body initiated against us by a patient.
4. Your clinician may occasionally choose to consult other professionals about a case. During a consultation we make every effort to avoid revealing the identity of a point. The other psychologist is also legally bound to the keep the information confidential.
5. As an agency contracted with the State of Oklahoma, records and information can be released to the Oklahoma Department of Mental Health and Substance Abuse Services for oversight activities as authorized by law, including conducting or arranging for medical review, auditing functions, including fraud, abuse detection and compliance programs. Please initial here: ________

Your signature below indicates that you have received a copy, read and understand THE PSYCHOLOGIST'S POLICY AND PRACTICES TO PROTECT THE PRIVACY OF YOUR HEALTH INFORMATION. Your signature below acknowledges that you have received, read and understand the contents of this document, which explains information related to therapy, the limits to confidentiality, contacting us, legal issues, fees for services, substance abuse issues and billing issues. You authorize this practice to submit bills and to furnish confidential information including but not limited to diagnoses and financial information to any insurer, third party payer, or welfare agency providing financial assistance for the services rendered. Your signature indicates that you assign and authorize payment directly to Poyner Psychological Services for any insurance or health plan benefits otherwise payable to you. A photocopy of this document is to be considered as valid as the original. You are aware that you may stop treatment at any time but agree to be financially responsible for the services you have already received. You certify that you have legal standing to authorize these professional services for your child or children. You agree to make a commitment to the treatment process. You acknowledge that financial responsibility for services is yours—even if you have insurance. You understand and agree that it is your responsibility to obtain any preauthorization of services required by your insurance—even if we have contacted your insurance and received authorization or have attempted to receive authorization. If you do not obtain preauthorization and it is required by your insurance, you acknowledge that you are responsible for those payments. You agree to ask questions about any part of this document that you may not understand or have concerns about. You agree to pay for services and cancellation no-show fees and give full consent for treatment.

Signature of Client (or parent of child):	**Date:**