Associates at Hope Harbor

Office Policies, Procedures, and Consent for Treatment

Welcome to our practice! Our goal is to offer you the most appropriate and up to date services in the most professional manner possible. You will be offered services specifically designed to help you. The services may include individual, couple, group, family therapy or assessment testing. Regardless we will provide you with a therapist that will accommodate your needs.

Appointments

Appointments are 50 minutes in length. Except in rare emergencies, you will be seen at the time scheduled. Because this time is set-aside just for you, it is important that you keep this appointment. It is understandable that circumstances may necessitate the cancellation of occasional appointments. In these appointments, we ask that you give at least **24 hours** notice of any appointment that you need to cancel. This will allow your time to be offered to another patient. **You will be charged the appointment fee for all appointments missed without 24 hours advance notice, except in the case of genuine emergencies or illness**.

Costs for Services

The fee for your treatment varies on the treatment you receive. The treatment and fee will be discussed with you prior to treatment. Payment is required at each session Patients who owe money and fail to make arrangements to pay may be referred to a collection agency.

Health Care Insurance

We do not accept any health coverage plans.

Confidentiality

Psychological services are best provided in an atmosphere of trust. You expect your therapist to be honest about your problems and progress. Your role is to be honest about your expectations for services, your compliance with treatment, and any other barriers to treatment. Because trust is so important, all services are confidential. What you discuss during your therapy session is kept confidential. No contents of the therapy sessions, whether verbal or written may be shared with another party without your written consent or the written consent of your legal guardian. Following are the limits of confidentiality.

Limits of Confidentiality:

What you discuss during your therapy session is kept confidential. No contents of the therapy sessions, whether verbal or written may be shared with another party without

your written consent or the written consent of your legal guardian. The following is a list of exceptions:

Duty to Warn and Protect If you disclose a plan or threat to harm yourself, the therapist must attempt to notify your family and notify legal authorities. In addition, if you disclose a plan to threat or harm another person, the therapist is required to warn the possible victim and notify legal authorities.

Abuse of Children and Vulnerable Adults If you disclose, or it is suspected, that there is abuse or harmful neglect of children or vulnerable adults (i.e. the elderly, disabled/incompetent), the therapist must report this information to the appropriate state agency and/or legal authorities.

Prenatal Exposure to Controlled Substances Therapists must report any admitted prenatal exposure to controlled substances that could be harmful to the mother or the child. I have received information on HIV and other infectious diseases.

Minors/Guardianship Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

I**nsurance Providers Insurance companies and other third-party payers** are given information that they request regarding services to the clients.

The type of information that may be requested includes: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, summaries, etc.

Emergencies

Clients with emergencies should contact 911 or go to the nearest emergency room if necessary.

Treatment Concerns

We adhere to the codes of ethics of the American Psychological Association and to the State of Kansas statute. Please feel free to discuss any concerns you have about your treatment with your therapist.

Therapy sessions carry both benefits and risks. Therapy sessions can significantly reduce the amount of distress someone is feeling, improve relationships, and/or resolve other specific issues. However, these improvements and any "cures" cannot be guaranteed for any condition due to the many variables that affect these therapy sessions. Experiencing uncomfortable feelings, discussing unpleasant situations and/or aspects of your life are considered risks of therapy sessions.

Associates at Hope Harbor Consent to Treatment

First Name_____ Middle _____ Last Name_____

DOB_____ Soc.Sec.# _____ - _____ - _____ Email_____

Address_____ City_____ State_____ Zip _____

Home Phone_____ Work _____ Cell _____

Marital Status_____ Employer _____

Emergency Contact_____ Relationship_____ Phone_____

I acknowledge that I have received, have read (or have had read to me), and understand the "Policies and Procedures" description about the therapy I am considering. I have had all my questions answered fully.

I do hereby seek and consent to take part in the treatment by the therapist named below. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as the results of treatment or any procedures provided by this therapist. I am aware that I may stop my treatment with this therapist at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.)

I know that I must call to cancel an appointment at least 24 hours before the time of the appointment. If I do not cancel or do not show up, I will be charged for that appointment. I understand that I will be responsible for full payment for such sessions.

I am aware that a third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive. It may also be necessary to provide treatment information such as notes to third party payers. I agree to allow the release of any information necessary for third party payment to be remitted. I also understand that if payment for the services I receive here is not made, the therapist may stop my treatment.

I am aware that I am fully responsible for payment for treatment I receive. I further understand that my therapist can employ the services of a collection agency to retrieve any monies I owe after a reasonable attempt has been made to request payment.

By signing below, I agree to the above assumption of risk and limits of confidentiality and understand their meanings and ramifications.

_____ _____

Client Signature (Client's Parent/ Guardian if under 18 **Date**

The therapist has discussed the issues above with the client (and/or his or her parent, guardian or representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____

Signature of Therapist **Date**

Court_____ Evaluation/Cost_____ Program/Cost_____