Psych Choices of the Delaware Valley
CONSENT FOR TREATMENT

Patient Name (Print): ___________________________________

- I certify that I have been provided information about the treatment I am to receive. I have had all my questions answered fully.
- I am consenting to take part in the treatment for myself or my child under 18, by provider(s) at Psych Choices of the Delaware Valley. I understand that I will take part in determining the treatment plan and that I have the right at any time to discontinue treatment, unless this treatment is ordered by law. I will only be responsible for payment for services I have already received, in addition to any fees for cancellation without sufficient (1 business day) notice.
- I understand that no promises have been made to me as to the results of treatment or of any medications or treatment methods provided to me.
- I understand that for a true psychiatric or medical emergency, I need to call 911 or go to the nearest emergency room. I understand that my provider will generally respond to voicemail messages left on his or her office extension or cell phone number within 24 to 48 hours, and that an answering service is available to me for urgent situations if I am being treated with psychiatric medications.
- I understand that information relating to mental health is specifically protected under state and federal law. I have been made aware that I can request a copy of the Notice of Privacy Practices for this practice. Information about my care will be provided to others only as permitted by law.
- I have read and understand the attached Guidelines for Confidentiality in Mental Health Treatment.
- My signature below shows that I understand and agree with all of these statements.

Signature of patient____ Date____________________

If client is under age 14, both parents must sign and date below. If consenting for a child age 14-17, parents must understand that the treatment provider may not release records to them without consent of the child, though parents may release records to another provider. Parents of children 14-17 do have the right to receive information sufficient for them to make an informed decision about the need for more therapy.

____

Parent or Guardian Signature Date

____

Parent or Guardian Signature Date

As treating clinician, I have discussed the issues above with the client and/or parents or guardians. My observations of this person's behavior and responses give me no reason to believe that this person is not competent to give informed and willing consent.

____

Signature of treating clinician Date

PSYCH CHOICES OF THE DELAWARE VALLEY
5060 STATE ROAD DREXEL HILL, PA 19026
(610) 626-8085 FAX (610) 626-8032

INSURANCE INFORMATION:

*If this form is not completed in full, we will not be able to bill your insurance

Insurance Type____

Patient SS#________________________Patient Date of Birth__________

Policy Holder SS#__________________ Policy Holder Date of Birth ________

Patient Relationship to Policy Holder:______________________________

INSURANCE AUTHORIZATION

Please initial each line.

_____ I hereby give permission to Psych Choices of the Delaware Valley to release any and all pertinent information to my insurance company for the purposes of treatment authorization and for payment of services rendered to me or my dependent.

____ My signature also directs my insurance company to make all payments directly to Psych Choices of the Delaware Valley.

____ I agree to pay all co-payments due when services are received.

____ I understand that I am fully responsible for all services rendered to me or my dependent should my insurance company refuse to pay the agreed charges.

____ I agree to notify Psych Choices of the Delaware Valley of any changes in the status of my insurance as soon as possible, and understand that a failure to do so many result in denial of payment from my insurance company due to timely filing. If the delay in billing is due to my not providing updated insurance information in a timely fashion, I will be responsible for all denied services out of pocket.

____ I understand that my treatment at Psych Choices of the Delaware Valley is not contingent upon my agreement to sign this authorization.

____ I have the right to revoke consent at any time via written communication to my therapist.

____ If I choose to revoke consent, I will be responsible for full fees out of pocket at the time of service.

____ I understand that this consent will remain in effect for the duration of treatment with Psych Choices of the Delaware Valley.

____ I authorize that a copy of this document can be used in place of the original.

I have been informed that I may revoke this authorization via written communication to my therapist at any time. I understand that this authorization is voluntary. I understand that I may have a copy of this form after I have signed it. I certify that this form has been fully explained to me and that I understand its contents.

______________________________________ ____________

Signature of Patient/Representative/Legal Guardian Date

____

Printed Name of Patient or Patient Representative

____

Relationship to Patient

PSYCH CHOICES OF THE DELAWARE VALLEY
5060 STATE RD DREXEL HILL, PA 19025
(610) 626-8085 FAX (610) 626-8032

RIGHTS AND RESPONSIBILITIES OF PATIENTS

Members have the following rights:

- To be treated with respect and dignity.
- To have fair treatment, regardless of race, religion, gender, ethnicity, age, disability, or source of payment.
- To have his or her treatment and other member information kept private.
- To have records released only with member permission or when required by law.
- To easily access timely care in a timely fashion.
- To know about treatment choices, regardless of cost or coverage.
- To share in the development of their treatment plan.
- To have clear and understandable information about his/her condition and treatment options.
- To have information about their insurer, its providers, its services, and its role in the treatment process.
- To ask about the provider's work history and training.
- To give input on the Member's Rights and Responsibility policy.
- To know about advocacy and community groups and prevention services.
- To freely file a complaint or appeal and to learn how to do so.
- To know of his/her rights and responsibilities in the treatment process.
- To receive services that will not jeopardize his/her employment.
- To list certain preferences in a provider.

Members have the following responsibilities:

- To treat those giving them care with dignity and respect.
- To give providers information needed to provide the best care.
- To ask questions about his/her care to help the member understand the recommended care.
- To follow the agreed upon treatment plan.
- To tell the provider, PCP, and any treating physician about all medications taken.
- To keep scheduled appointments.
- To inform the provider when the treatment plan is not working.
- To pay any necessary fees at the time of the appointment.
- To report abuse or fraud.
- To report concerns about the quality of care rendered by the provider.

I have read and understand the above stated rights and responsibilities and agree to abide by these rights and responsibilities.

______________________________________ _____________
Patient Signature/Representative/Legal Guardian Date

Psych Choices of the Delaware Valley
Guidelines for Confidentiality in Mental Health Treatment

Confidentiality in psychotherapy and psychiatric treatment follows federal and state laws about protected health information. That means that in most cases, information about you cannot be shared without your written permission. However, there are exceptions.

Your record at Psych Choices is electronic. It may not be shared with others outside the practice without your written permission, however, all providers at Psych Choices have electronic access to all patient records.

We sometimes may talk with other professionals about your treatment. If you are being treated by another professional at Psych Choices, we will often discussing your care with that person to coordinate care. We may also discuss your case, without using your name, in a consultation with an outside professional, if we need to seek advice about your care.

If you are in couple or family therapy, and you tell us something you wish to keep a secret from other family members, we cannot always promise to keep it confidential. We will work with you to decide on the best way to handle the situation.

In order for your insurance company to pay us, we must submit information about your diagnosis and the dates of treatment. In rare cases they will request more information, and these companies have the right to review your chart with all our notes, if they so choose.

If you are threatening harm to yourself, we may need to contact another professional and/or a family member to try to save your life.

If you are threatening harm to someone else, we are required to do what is necessary to protect that person, which may include contacting that person and the police.

If we believe you are abusing a child, elderly, or disabled person, we must file a report with the state agency. In most cases, will let you know before doing this.

You can prevent us from testifying about you in a court proceeding, even under subpoena. However, if there is a court order stating that we must testify or submit records, then we must do so. We will let you know if this happens.

If your child is in treatment with us, you have the legal right to see our case notes and discuss his or her care with us. However, if your child is between 14 and 18, we will need to keep his or her information confidential, so the child can trust us. We will always tell you if we believe your child to be in danger.

If you are involved in a custody or divorce dispute, you need to know that our policy is not to testify in any legal disputes. We believe that therapy and court evaluations are very different, mutually exclusive processes.

Any information that you also share outside of therapy, willingly and publicly, is not considered protected or confidential. *Please remember that e-mails (even to your therapist), faxes, and texts are by their nature not protected or confidential;* telephone is preferred for communication with your doctor or therapist.

My signature below indicates that I have read and understood these confidentiality guidelines.

____________________________________ ____________________

Patient or Guardian Date

Psych Choices of the Delaware Valley
5060 State Road, Drexel Hill, PA 19026 -- Office (610) 626-8085 Fax (610) 626-8032

Consent to Release Protected Health Information

Your health information is protected and will not be released without your consent. Our Notice of Privacy Practices is available on our website at www.PsychChoices.com. Communication between your mental health provider and your other health professionals allows us to provide the most effective care. **It is our policy to collaborate you're your doctors. We usually write a simple letter to referring doctors or primary care doctors when you receive treatment here.** If you prefer that we do not send this letter, please write "Refused" on the signature line below instead of signing.

Release of Information to my Primary Doctor or Other Health Care Provider:

I understand that I am not required to give consent, and that this release is in compliance with the HIPAA laws governing release of confidential health records. I hereby release the source of the records from liability arising from release of the records. I agree that a copy of this form is acceptable. If records are to be transmitted electronically I understand the possible risks. I understand that I may consent to release of some but not all of my health information, if I so choose. I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it and that in any event this consent shall expire twelve (12) months from the date of signature, unless another date is specified.

I, (name) ______________________________________ (date of birth)____________, authorize Psych Choices of the Delaware Valley to release information about my (or my child's) treatment at Psych Choices **to the health care provider named below:**

Referring or Primary Care Doctor's Name: (write "none" if none)____

Doctor's Phone_____________________________ Fax (if known) ____________________________

Address (if known)__________________________City, State, Zip _____________________________

By signing below, I give my consent to disclosure of health information TO and/or FROM my health care provider:

( ) Psych Choices of the Delaware Valley may release any applicable mental health information TO my health care provider named above, and including telephone contact about my condition.

X ____Date: ______________________
Patient or Guardian Signature

By signing below, I give my consent for the health care provider listed above to release my health information to Psych Choices of the Delaware Valley:

X ____Date: ______________________
Patient or Guardian Signature

By signing below, I give my consent to the release of my (or my child's) health information to the family members or other persons listed below:

(Name) ________________________________ Relationship___________ Phone____________________

(Name) ________________________________ Relationship___________ Phone____________________

____Date ______________________
Patient/Guardian signature

CREDIT CARD AUTHORIZATION FORM

If you have ever checked into a hotel or rented a car, the first thing you are asked for is a credit card, which is imprinted and later used to pay your bill. This is an advantage for both you and the hotel or rental company, since it makes checkout easier, faster, and more efficient.

We have implemented a similar policy. You will be asked for a credit card at the time you check in and the information will be held securely. You will always have the option to pay fees using another payment method, if you do so in a timely manner. Charges to the credit card will be determined as follows:

Copays/Self Pay Charges – Copays are due on the date of service, per your contract with your insurance company. Self-pay charges are due on the date of service, per your agreement with our office. You may present another method of payment prior to, or at the time of service. ***If another method of payment is not offered by the date of service, your credit card will be charged.***

Coinsurance and/or Deductibles – These amounts are determined after your insurance company has completed processing your claim. At that time, if a balance remains on your account, a statement will be sent. You will have 45 days to make a payment on the account using another method of payment. ***If, at 45 days, no payment has been received, your credit card will be charged for any balance over 45 days old***.

Psychological Testing/Dietician Services/Phone Sessions/Refill Fees – These are some examples of services that may or may not be billable to your insurance. For this reason, we will require a credit card on file if you are scheduled for any of these treatments, or incur any of these fees. If we are able to bill a service, and a balance remains on your account after your insurance company has processed your claim, a statement will be sent. You will have 45 days to make a payment on the account using another method of payment. ***If, at 45 days, no payment has been received, your credit card will be charged for any balance over 45 days old.***

Late Cancellation or No Show Charges – These charges are generated by your provider if you fail to show up for a scheduled appointment, or if you do not give adequate notice (24 hours) for canceling an appointment. If you incur such a charge, a statement will be sent. You will have 45 days to make a payment on the account using another method of payment. ***If, at 45 days, no payment has been received, your credit card will be charged for any balance over 45 days old.***

Our Credit Card on File Program is intended as both an advantage to you and to our office. You will no longer have to write out and mail us checks, and in turn, it will greatly decrease the number of statements that we have to generate and send out. The combination will benefit everybody in helping to keep the cost of health care down.

This will not compromise your ability to dispute a charge or question your insurance company's determination of payment. ****PLEASE NOTE:** If the Credit Card provided expires, becomes invalid, or lacks sufficient funds, it will be required that you update your Credit Card on File information and/or pay your balance in full in order to reschedule with your provider.

Authorization to Charge my Credit Card

Patient Name (printed): ____ **Patient** Date of Birth: ___/___/______

Choose One: ❑ Send billing statements electronically to Patient Portal ❑ Please send me a paper statement instead

SELECT AN OPTION (required):

❑ Check here to add card information below to be kept on file in our secure PCI DSS compliant system
❑ Check here to keep the card provided during Intake on file (Card ending in __ __ __ __)
❑ Check here if you are refusing to keep a card on file. Reason **(required):**
____

Until further notice, I authorize Psych Choices to charge balances on this account to the following credit card:
Name on Card: ___________________________ Cardholder Signature: ___________________________ Date: __/__/___
Card Number: ________-________-________-________ Exp. Date (mm/yy): ____/____ 3-Digit Sec. #: ___ ___ ___
Billing Address: _________________________________ City/State: _____________________ Billing Zip Code: _________

Phone, Attendance and Payment Policies - Psych Choices of the Delaware Valley
Please Read and Initial Each Item

Phone Calls:

1. ____I agree that I will use the office number, 610-626-8085, for all routine matters such as scheduling and billing questions. I understand that in a true medical or psychiatric emergency, I will go to the nearest emergency room, or call 911 or a local crisis center (such as the one at Mercy Fitzgerald, 610-237-4210).
2. ____I understand that while I may leave a message about clinical matters on my clinician's extension, that I may be charged a fee for calls (phone sessions) lasting more than 10 minutes ($25 for each 15 minutes). I understand that phone sessions cannot be billed to health insurance.
3. ____I understand that if I call for a medication refill, and the refill is needed because I missed an appointment, my provider may charge a $25 refill fee.

Payment for Services, No Show and Late Cancel Fees:

4. ____ I agree to pay any fees due by cash, check, or credit card at the time of service.
5. ____ I understand that if I miss an appointment or cancel with less than 1 business days' notice, I will be charged a fee.
6. ____I understand that because my provider's time is very valuable and there are many patients waiting for appointments, that I have been asked to keep a valid credit card on file with this office. If I do not show up for my appointment, or if I cancel with less than 1 business days' notice (except in cases of emergency), my credit card will be charged a missed appointment fee without prior notice except as stated here.
7. **____ I understand that missed appointment fees are as follows:**
    - For initial evaluation by a psychiatrist - $150
    - For initial evaluation by a nurse practitioner or nutritionist - $100
    - For 30 minute follow up appointment with psychiatrist - $100
    - For 30 minute follow up appointment with nurse practitioner or nutritionist - $50
    - For 45 minute therapy session (masters level therapist) - $65
    - For 45 minute therapy session (doctoral level therapist) - $75
8. ____ I understand that if my card must be charged and the card is declined, that I may not have an appointment with any provider (therapist or psychiatrist) in this practice until I provide the office with a current, valid credit card.
9. ____I understand that if I am unable to provide a valid credit card, then I must make payment by cash or money order within two weeks in order to continue to be seen at Psych Choices..
10. ____I understand that in certain cases, if I cannot pay my balance, a payment plan may be arranged by calling the billing office at 610-626-8085 ext. 201.
11. ____I understand that if I receive two statements in a row and do not pay my balance, or make a payment agreement with the billing office, I will receive one final statement and my account will be sent to collections.
12. ____I understand that if my account is sent to collections, a collections fee of **30%** will be added to my outstanding bill and I will be required to pay that amount in addition to my original balance.
13. ____If I do not show for an appointment twice in a row, or if I have a sustained pattern of frequent cancellations or no shows and have not been able to resolve the pattern with my treatment provider, my case may be closed. I understand my provider will make at least one attempt to resolve this with me by telephone or letter prior to closing the case.
14. ____I understand that a copy of this document is to be kept in my file at Psych Choices, and that I have been given a second copy to keep.

Signed: ____ Date:__________________

Print Patient Name: ____

PATIENT COPY **Phone, Attendance and Payment Policies - Psych Choices of the Delaware Valley**
Please Read and Initial Each Item

Phone Calls:

1. I agree that I will use the office number, 610-626-8085, for all routine matters such as scheduling and billing questions. I understand that in a true medical or psychiatric emergency, I will go to the nearest emergency room, or call 911 or a local crisis center (such as the one at Mercy Fitzgerald, 610-237-4210).

2. ____I understand that while I may leave a message about clinical matters on my clinician's extension, that I may be charged a fee for calls (phone sessions) lasting more than 10 minutes ($25 for each 15 minutes). I understand that phone sessions cannot be billed to health insurance.

3. ____I understand that if I call for a medication refill, and the refill is needed because I missed an appointment, my provider may charge a $25 refill fee.

Payment for Services, No Show and Late Cancel Fees:

4. ____ I agree to pay any fees due by cash, check, or credit card at the time of service.
5. ____ I understand that if I miss an appointment or cancel with less than 1 business days' notice, I will be charged a fee.
6. ____I understand that because my provider's time is very valuable and there are many patients waiting for appointments, that I have been asked to keep a valid credit card on file with this office. If I do not show up for my appointment, or if I cancel with less than 1 business days' notice (except in cases of emergency), my credit card will be charged a missed appointment fee without prior notice except as stated here.
7. **____ I understand that missed appointment fees are as follows:**
    - For initial evaluation by a psychiatrist - $150
    - For initial evaluation by a nurse practitioner or nutritionist - $100
    - For 30 minute follow up appointment with psychiatrist - $100
    - For 30 minute follow up appointment with nurse practitioner or nutritionist - $50
    - For 45 minute therapy session (masters level therapist) - $65
    - For 45 minute therapy session (doctoral level therapist) - $75
8. ____ I understand that if my card must be charged and the card is declined, that I may not have an appointment with any provider (therapist or psychiatrist) in this practice until I provide the office with a current, valid credit card.
9. ____I understand that if I am unable to provide a valid credit card, then I must make payment by cash or money order within two weeks in order to continue to be seen at Psych Choices..
10. ____I understand that in certain cases, if I cannot pay my balance, a payment plan may be arranged by calling the billing office at 610-626-8085 ext. 201.
11. ____I understand that if I receive two statements in a row and do not pay my balance, or make a payment agreement with the billing office, I will receive one final statement and my account will be sent to collections.
12. ____I understand that if my account is sent to collections, a collections fee of **30%** will be added to my outstanding bill and I will be required to pay that amount in addition to my original balance.
13. ____If I do not show for an appointment twice in a row, or if I have a sustained pattern of frequent cancellations or no shows and have not been able to resolve the pattern with my treatment provider, my case may be closed. I understand my provider will make at least one attempt to resolve this with me by telephone or letter prior to closing the case.
14. ____I understand that a copy of this document is to be kept in my file at Psych Choices, and that I have been given a second copy to keep.

Signed: ____ Date:_______________

Psych Choices Patient Satisfaction Survey

Please complete after your first session. Our policy is to encourage patient feedback. Similar forms are always available in the waiting rooms as well as on our website and we encourage you to complete one at any time.

Patient name____ Date_______________

Please answer the following questions by marking the appropriate line with an x or check mark.

Visits with Your Provider **Your Provider's Name**: ____

(If you see more than one person in this practice, feel free to complete a separate form for each provider)

Thinking about the provider you met or have been meeting with, how would you rate:

	Excellent	Very Good	Good	Fair	Poor	N/A
How prepared this provider was for your visits	__	__	__	__	__	__
Attention this provider paid to what you had to say	__	__	__	__	__	__
How well this provider understood your concerns	__	__	__	__	__	__
Thoroughness and competence of this provider	__	__	__	__	__	__
Ease of getting an appointment with this provider	__	__	__	__	__	__

Continuing to think about the visit(s) you've had with this behavioral health provider, please rate your agreement with the following statements:

Provider is focused on developing the goals for my counseling/treatment	__	__	__	__	__	__
This provider gave me as much information as I wanted about what I could do to manage my condition.	__	__	__	__	__	__
This provider and other behavioral health providers, if any, worked as a team in coordinating my care.	__	__	__	__	__	__
This provider and my primary medical doctor, if involved, worked as a team in coordinating my care.	__	__	__	__	__	__

Now, please comment on your experience with our office staff:

Professional and courteous	__	__	__	__	__	__
Knowledgeable and helpful	__	__	__	__	__	__

How likely would you be to recommend Psych Choices to a friend or family member? (circle the number below)

Would definitely ***NOT*** recommend / Would definitely recommend
1 2 3 5 4 6 7 8 9 10

Please use the reverse side for any comments you'd like to make about your experience with Psych Choices.