Clinical Counseling Services of Cincinnati
4055 Executive Park Drive, Suite 210
Cincinnati, OH 45241
513-469-6226

CONSENT FOR TREATMENT

Welcome to my practice. This document contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. Although these documents are long and sometimes complex, it is very important that you understand them. When you sign this document, it will also represent an agreement between us. We can discuss any questions you have when you sign them or at any time in the future.

Appointment and Fees

Appointments usually last about _____ minutes. I encourage you to arrive a few minutes early so we can start on time and use the full time allotted for your session. All sessions will need to end on time.

My fee for the initial assessment is $_____. This session is mostly for collecting information. During this time, I gather history about you and the reasons you chose to start counseling. We will talk about the goals you want to achieve and will develop a treatment plan which will guide the counseling process.

Subsequent treatment sessions are $____. Extended sessions (90 minutes) are $____. This may apply for some couple appointments or family sessions. Please know the time scheduled for your appointment is assigned only to you. Therefore, if you need to cancel or reschedule a session, please contact me at least ____ hours in advance. For appointments missed or not cancelled within ____ hours, there will be a $____ missed session charge. I understand emergencies arise. Please call me so we can discuss any unforeseen circumstances.

Payment is due at the time of service. I accept cash, check or credit cards. Credit cards include HSA or FSA cards. Any checks returned to my office are subject to an additional fee of up to $____ to cover bank charges. If you refuse to pay your debt, I reserve the right to use an attorney or collection agency to secure payment.

Insurance

If you wish to use insurance, please contact your insurance carrier for your outpatient mental health benefits including number of visits, copayments or co-insurance. Some plans may limit the number of visits or require preauthorization. Your insurance company will be billed for services. Copays or coinsurance are due at the time services are provided. Your signature below gives me permission to provide the necessary information to the insurance company in order for them to process the claim.

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If I am not a participating provider for your insurance plan, I will supply you with a receipt of payment for services, which you can submit to your insurance company for reimbursement. Please note that not all insurance companies reimburse for out-of-network providers. If you prefer to use a participating provider, I can refer you to a colleague.

Confidentiality
My policies about confidentiality, as well as other information about your privacy rights, are fully described in a separate document entitled Clients Rights and Responsibilities as directed by the State of Ohio. You have been provided with a copy of that document. In summary, it is important to understand that the matters discussed during sessions are kept confidential. There are certain exceptions which include; (1) you give me written permission to share this information (2) you indicate you do not feel you can keep yourself safe (3) you believe you are a safety threat to someone else (4) someone else is threating your safety (5) the safety of a child, disabled or elderly person is at risk.

Contacting Me
Office hours are generally ______ - ______, __________ - __________. You may leave a message on my confidential voice mail and your call will be returned within 1-2 business days. If you do not hear from me or I am unable to reach you, and you feel you cannot wait for a return call or if you feel unable to keep yourself safe, please do not hesitate to call 911 or go to your nearest Emergency Department.

Consent to Counseling
Your signature below indicates that you have read this Agreement and the Client Rights and Responsibilities and agree to their terms.

____ Date______________
Client Signature

____
Client Name (Printed)

____
Clinical Counseling Services signature