DISCLOSURE STATEMENT AND CONSENT TO TREATMENT
~ *ICHANGE* ~

THERAPIST TRAINING AND CREDENTIALS:

Thank you for choosing *ICHANGE* for your emotional, mental, and relationship needs. Your therapist with ICHANGE has received an advanced degree in one or more of the following fields: marriage and family therapy, social work, professional counseling, or psychology. Your therapist is licensed through the state of Michigan. If your therapist holds a limited license or it is required by the particular insurance company, that therapist will be supervised by a fully licensed clinician in the practice.

Therapeutically our clinicians are trained to work with individuals, couples, and families. We make up a group practice and are all independent private practitioners, not affiliated with any medical center or hospital. We are not available for emergency services, and advise that in these cases, contact Community Mental Health agency or your nearest medical center/hospital. We are not physicians and do not prescribe medications or perform medical procedures, however, with written consent, we look forward to collaborating with family physicians or psychiatrists. Initial Here _____

THERAPY SPECIFICS:

Therapy sessions last 45-60 minutes beginning on the hour. Sessions are typically held one to two times per week. Initial sessions are dedicated to assessment, which involves gathering information about you and your family and the problem bringing you to therapy. To gain the full benefits of therapy it is strongly encouraged that you fully participate in the sessions through regular attendance and willingness to try alternative ICHANGE for both the problem and its solutions. It is difficult to determine how many sessions will be necessary for an individual, couple, or family to make significant and long-lasting changes. It is recommended however, that you allow at least eight sessions, followed by reevaluation.
Initial Here _____

The initial assessment meeting is charged at $210. Subsequent sessions are charged based on time: 60-minute sessions are **$175**. Obligation for payment is understood not to be dependent upon the client's receiving third party reimbursement from insurance coverage. While the practice certainly supports and encourages clients to pursue the maximum amount of financial reimbursement from third party payers (such as health insurance agencies), it is ultimately the client's responsibility to insure that s/he receives all third party payments for which s/he may be eligible. Initial Here _____

ICHANGE will submit all insurance billing for health insurance companies that we are networked with. **All co-payments are due at the time of service.** There is a returned check fee of **$35.** You may still choose to pay for your balances using another form of payment.

Session fees cover the following professional services:

- Therapy for the individual, couple, or family system
- Initial and ongoing assessment
- Treatment planning
- Time spent in consultation with other professionals

Phone contact, other than to schedule appointments, is considered a consultation and billed at $30 per 15 minutes. Report writing is charged at a rate of $150 per hour. Initial Here _____

CLIENT RIGHTS AND RESPONSIBILITIES:

Although you may choose to end therapy at any time, you are responsible to attend scheduled sessions. Unless a session is cancelled 24 hours in advance, you will be responsible to remit payment of $75 for a missed session. This is a strict policy with no exceptions. Please remember that if you are using insurance, charges cannot be submitted for missed sessions and you will be held responsible for the $75 charge as specified above. In cases of excessive absences it will be your therapist's discretion to terminate services at PTS and refer your care elsewhere. If a client owes on their account, payment is expected during each visit in order to continue scheduling. If a balance exists whereby no payments have been made in 30 days, PTS will attempt to contact you. If no payments are made as a result of these attempts, PTS contracts with an external collections service that will then pursue settling the amount due. Initial Here _____

Information disclosed in session will be kept confidential and not revealed to any other person or agency without your written permission. However, there are exceptional circumstances that require your therapist to share information obtained in a therapy session without your permission. These exceptional situations include: 1) If you threaten serious bodily harm to yourself or another person, your therapist is required by law to inform the intended victim and/or the appropriate law enforcement agency; 2) If your therapist is subpoenaed by a court of law to provide specific information, s/he is obligated to comply; and 3) If you reveal information to your therapist about child abuse and/or neglect, s/he is required by law to report this information to the appropriate authority. Initial Here _____

After you have carefully read this information and have received satisfactory answers to any questions that may have surfaced, please sign this contract below. Anyone over age 18 must sign this form in order to be treated through ICHANGE behavioral health services. Parents or legal guardians must sign for persons under 18 years old. Initial Here _____

I have read and understand the information provided in this document and agree to the procedures and conditions outlined. I understand that I may terminate therapy at any time and will be financially responsible for those sessions already completed.

Patient name (please print):_____

Patient signature: _____ Date: _____
(Parent signature for minor client)

Therapist Signature: _____ Date: _____

At times there are persons who join the therapy process who are not identified as the "patient", however are important to treatment. By signing below you acknowledge this is a health care setting. The protections in place through our practice's HIPAA policies protect you to the same degree as the primary patient. If a minor is joining the therapy process, the parent or legal guardian must consent to this participation by signing below.

Signature:_____Date: _____

Signature:_____Date: _____

_____Initial here to acknowledge that you have read the Notice of Privacy Practices and that a copy of the Notice has been provided to you upon your request.

Insurance Consent

By signing below I give permission ICHANGE to release all required information to my insurance company to attain payment for services rendered. I understand that if my insurance company does not cover these services, I am responsible for the balance.

_____ _____
Signature of insured Date

Addendum to Consent to Treatment: Cell Phone Consent

As a contractual therapist at ICHANGE Therapy Services I offer you, the client and/or guardian of the client, the privilege and ability of contacting me via cell phone. This communication includes both phone calls as well as text messaging. Know that this information is indeed a privilege that can be revoked if the therapist deems the client to be abusing the privilege. This definition of abuse is left to the discretion of the therapist and may include, but is not limited to: excessive calls and texts despite the therapist addressing the concern or attempting to contact the therapist after normal business hours. Initial Here _____

Please know that because you call or text does not mean you will get a reply immediately or at all. Some concerns brought up in a text message are better addressed in the therapy session. Please note that the intention of receiving this therapists' phone number is primarily for scheduling purposes and to increase efficiency of communication. Initial Here _____

Providing this number in no way indicates 24-hour access to my services, nor should it be considered an emergency resource. If you are in crisis, you are still instructed to contact your local Community Mental Health agency (listed below), call 911 or go to your local Emergency Room.

Livingston County: (517) 548-0081 Ingham County: (517) 346-8200 Oakland County: (800) 231-1127

Please respect normal business hours when calling or texting. Initial Here _____

HIPAA Privacy Disclosure:

Please be advised that communication via cell phone is not secure. While all efforts will be made to maintain your privacy, the confidentiality of cell phone calls or texts cannot be guaranteed. Initial Here _____

By signing below, I understand and accept the conditions above. Your care at ICHANGE will not change should you decline to sign this section of the form. It is optional.

_____ _____
Client Signature (or Parent/Legal Guardian Signature if client is a minor) Date