

**American Psychiatric Group, P.A.**

**Name of Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CONSENT FOR TREATMENT**

I hereby give my voluntary permission to American Psychiatric Group to provide my Mental Health services via the Outpatient Mental Health Clinic (OMHC).

**CONFIDENTIALITY**

I understand that the confidentiality between my therapist and me is protected by law and that information about my treatment can only be released with my written permission. I understand that there are some exceptions:

• In most legal proceedings the therapist is prevented from providing information about the treatment. However, a judge can require the therapist to testify and/or release records.

• The therapist is required by law to report if an elderly or disabled person is being abused. The therapist is also required to report past instances of this abuse when specific information about the abuser is available.

• The therapist is required to warn a potential victim if a client is threatening serious injury to someone. The therapist may be required to hospitalize the client and/or contact family members if the client threatens to harm him/herself.

I understand that if any of these situations should occur, my therapist will make every effort to openly discuss this with me before taking any action.

**REVOCATION OF CONSENT**

This Consent will remain in effect for the duration of my treatment with American Psychiatric Group unless revoked in writing.

**RISKS AND OPPORTUNITIES IN THERAPY**

Therapy has potential emotional risks including the emergence of thoughts or feelings that may be painful, scary, and/or disruptive. You are encouraged to discuss these and other feelings with your therapist should they arise. Those who choose to engage in therapy are making the informed choice to continue on the basis that doing so may provide the opportunity for positive personal growth, alleviation of bothersome symptoms, and improvement in functionality. As therapy is an individual process, I understand that no guarantees may be made regarding efficacy for a particular individual. I acknowledge that my therapy will be individualized based on my personal needs and goals.

If I opt to participate in medication management services, the Prescriber will discuss potential risks and benefits of prescribed medications with me at the time of prescription.

**CLIENT RESPONSIBILITES**

I understand that time is allocated for my attendance and that if I am not able to attend on the day/time of my appointment and/or within the agreed upon timeframe, I will provide at least 24 hours’ notice of cancellation. Repeated failure to do so may result in case closure.

**TRANSFER, REFERRAL, OR SERVICE INTERRUPTION**

In the event that the clinician with whom I have been working leaves the practice, as much notice as possible regarding said change will be provided. I may also notify the agency should I decide I wish to change providers. In either case, options for transfer within the agency, transfer outside of the agency, and other referrals will be made available based on the client’s needs and preferences.

**CONSENT FOR RESEARCH**

In the event that research is to be conducted, I acknowledge that I will be given the opportunity to accept or refuse participation and that there is no implied or expressed penalty should I decline to participate.

**RELEASE OF INFORMATION AND AUTHORIZATION TO PAY**

**INSURANCE BENEFITS**

I hereby authorize the American Psychiatric Group staff to apply for payment from my insurer for services provided, understanding that the release of some protected information will be necessary. I authorize payment directly to the American Psychiatric Group. I permit a copy of this authorization to be used in place of the original and it may be retained on file.

**PAYMENT AGREEMENT AND FEE STRUCTURE**

I understand that every effort will be made to bill my insurance appropriately if insurance is present. I also understand that any amounts not covered by insurance are my responsibility and may be billed to me.

Services with Psychiatrist or Nurse Practitioner

Psychiatric Evaluation: $300 Follow-up/Med Management Appt: $150

Services with Other Providers

Initial Evaluation/Intake (Any Program): $200 45 Min Session (Individual, Family, Etc.): $150

30 Min Session (Individual, Family, Etc.): $100 45-60 Min Group: $75

Client signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Revised 10/2018