Dr Townsend & Associates

Comprehensive Counseling Services

Consent for Treatment and Client Information

Thank you for choosing Dr. Townsend & Associates, P.A. for your counseling and evaluation needs. We have listed below some helpful information regarding services with our practice. Please review the following information. Please sign at the bottom of the last page to indicate that you have reviewed this information.

Length of Treatment

Psychotherapy typically involves regular sessions, 45 minutes in length. Duration of treatment varies depending on the nature of the problem and your individual needs.

Confidentiality

Information shared with a mental health professional is kept strictly confidential and is not disclosed without your written permission.

Confidentiality is **not guaranteed** in cases of : (a) danger to yourself or others (e.g., planning to hurt others or yourself); (b) situations in which either children under the age of 18, disabled persons or elderly persons who are under the care of others are endangered (examples of endangerment are sexual or physical abuse, or neglect) or (c) when you are going to violate a major law.

If you wish for your insurance company to pay for your visits, they will require information regarding your diagnosis, and possibly additional information such as psychological history and the treatment plan and goals of therapy. Your therapist can provide you with the information that is typically requested from your insurance provider.

Should, during your treatment at Dr. Townsend & Associates, PA, you ever be involved in a legal situation your signature below acknowledges that you have been informed that there will be no one sided conferences with an opposing attorney without written confirmation from yourself, by court order or as required by law or Florida Regulations.

Should psychological testing be conducted during your treatment at Dr. Townsend & Associates, PA, please note that by signing below you acknowledge that raw test data will not be released to anyone other than a licensed clinical psychologist, an appropriately licensed & trained individual or by court order.

Fee Policies

The ordinary charge for an individual or joint therapy session is $150.00. Charges for psychological evaluation may require a deposit that will be discussed with clients prior to the evaluation. If you need to cancel an appointment, 24 hours notice is appreciated. Otherwise, cancellation charges will apply. Please be aware that insurance carriers will not cover cancellation charges.

If you have mental health insurance coverage, our office will bill your carrier if appropriate and/or assist with insurance reimbursement. Please be aware that charges are the client's responsibility. In addition, any co-payment necessary should be made at the time of the session.

Telephone consultations, preparation of records, and correspondence are billed pro-rated if substantial time is required. Court testimony charges are $500.00 per hour, portal to portal. In addition, patient will be responsible for preparation time charges.

Our office reserves the right to engage the services of a collection agency in the event of unpaid balances. Charges for collection efforts also become the client's responsibility.

Emergencies

When a client's therapist is unavailable, arrangements can be made for coverage or telephone contact as necessary. In case of life-threatening emergencies please go to your local hospital emergency room or call 911. During the normal workday (Monday - Friday, 9:00 a.m. to 5:00 p.m.) please call the office and discuss your emergency with our secretaries. They will then have the on-call therapist speak with you.

Accompaniment of Guardians for all Minor Children

It is the policy of Dr. Townsend & Associates, PA that all minor children be accompanied by a parent or legal guardian at all times while on the premises and that said parent or guardian or designated adult remain on the premises at all times whether the child is with them in the lobby area or in session. Children who are over the age of 16 may attend therapy sessions without the accompaniment of a parent or guardian if said parent or guardian signs a release giving their permission for the child to attend therapy without their being present.

As a parent or guardian your signature below allows Dr. Townsend & Associates, PA to obtain emergency medical care for your child, at your expense, if this becomes necessary based on staff decision. The latter applies if a legal guardian/parent is not present at the time of the crisis/emergency.

Physician Contact

Physical and psychological symptoms often interact. We encourage you to seek medical consultation, if warranted. In addition, medication may sometimes be helpful for psychological disorders. When appropriate, referral for medical/psychiatric consultation can be arranged.

We may ask a client's permission to contact their primary care or specialist physician regarding treatment, in order to coordinate your psychological and medical care.

Freedom to Withdraw

You have the right to end therapy at any time and are obligated only to pay for completed sessions or fees incurred by not canceling 24 hours in advance. If requested, a therapist may provide a client with names of other qualified psychotherapists, either in this office or in another practice.

We appreciate clients informing their therapist if they do want to discontinue their therapy, although this not a requirement. Your therapist also has the right to terminate outpatient care.

Reminder Call Request

By circling YES below, I formally request that I receive reminder calls/emails for appointments, workshop availability or other clinical activities. The number I would prefer to be called at is ( )_____ The email I would prefer to receive reminders is: _____

If you have voice mail or an answering machine please indicate your desire as to whether staff should leave a message by circling the appropriate answer below.

YES - Please leave a message NO - I would prefer no message be left

By signing below, I acknowledge that I have reviewed the Consent for Treatment and Client Information Form. Should I wish to receive a copy I can request a copy from the front office staff.

Privacy Practices Statement

Dr. Townsend & Associates, P.A. adheres to stringent HIPPA guidelines. Should you wish to receive a copy of our Privacy Practices, please request a copy from the front office staff. By signing below, I acknowledge that I have been informed that I may receive a copy of the Privacy Practices at my request. I recognize that I have 72 hours to remove my approval to proceed with the requirements outlined in HIPAA.

Informed Consent

By signing below, I acknowledge I have read and understand the preceding statements, have had the opportunity to ask questions about them and agree to begin treatment with Dr. Townsend & Associates, P.A.

_____ _____

Patient Signature Date

Revised 2014