Consent for Treatment and Fee Agreement

Jen Rapanos, LMSW
Licensed Master of Social Worker State of Michigan
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This document contains important information about my professional services and business policies. Please read it carefully and note any questions you might have so that we can discuss them. When you sign this document, it will represent an agreement between us.

MENTAL HEALTH SERVICES: I strive to create a space that is supportive and nurturing and where therapy is viewed as a resource and cooperative collaboration between therapist, child and parent(s). Though there are no guarantees, therapy has been proven to have significant benefits for individuals who are willing to be an active participant in the process of change. Being an active participant may mean that you engage in problem solving, explore new ideas and feelings, and practice new skills. Many of the skills learned in-session are encouraged to become a regular practice through what we call *home practices*. Home practices provide your child with opportunities to build more awareness and coping skills to help support them in everyday life. Like most things in life, we become more skilled and well-versed in something that we put into practice. Parent(s) are often encouraged to be an active participate in therapy. You may be invited into a portion of our scheduled sessions or we may schedule parent only sessions. This provides parents an opportunity to learn how to best support their child with home practices.

Please note too that therapy may evoke powerful responses and feelings at times, you are encouraged to ask questions and offer ideas of your own regarding your treatment.

If at any time you wish to terminate therapy, or decide to seek out services from another professional you have every right to do so. Please feel free to discuss this openly with me at any time.

APPOINTMENTS: In order to get the most out of a session, please arrive on time, as we cannot extend a session past the time scheduled. Beyond the first appointment (Intake Session w/ parent or guardian) most sessions last between 45 and 60 minutes. Generally, sessions with children/adolescents are 45 minutes and adults 60 minutes. A 24-hour advance notice of a cancellation is required to avoid a **missed appointment fee**, unless we both agree that you were unable to attend due to circumstances beyond your control.

PAYMENT: If you choose access your health insurance for mental health services, it is very important that you determine exactly what mental health services your insurance policy covers. If you have coverage through your insurance policy, you are responsible for any deductible or co-pays at the time of service. **All payments are collected at the time of service**. I accept check or credit card for payment.

If you have an insurance other than those I am paneled with, you will be responsible for the cost of services in full. If requested, I am able to provide you with a receipt that can be submitted to your insurance company or that can be retained for tax purposes.

Out-of-Session Services (10 minutes or less) such as telephone conversations or creating a brief summaries of treatment will not be charged. However, time devoted to other professional out-of-session services including school visits, lengthy consultations in person and by phone with other professionals, lengthy telephone conversations with the client or parent/guardian of the client or generating reports will be charged as an out-of-session service. Fees for these professional services will be agreed upon when they are requested. Please note that these services may not be covered by your insurance and you may be responsible for paying these out of session services.

You will be responsible for a missed appointment fee of $55 for all appointments that were not canceled or rescheduled within 24 hours of the scheduled time. Insurance does not cover missed appointments so this will be an out-of-pocket cost. There will be a $35 Returned Check Fee for any checks returned for insufficient funds.

If your account has not been paid for whatever reason for more than 90 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, those costs will be included in the claim. In most collection situations, the only information we release regarding a patient's treatment is his/her name, the nature of the services provided and the amount due.

CONFIDENTIALITY: The information you share with me is held in the strictest confidence. That means information about you cannot leave my office without your permission. Should you want to share information with another professional, you will need to sign a release form giving me permission to do so. In general, all communications between client and therapist is protected by law, however there are some exceptions: (1) The client authorized the release of information. (2) There is evidence or reasonable suspicion of child/elder abuse and or neglect. (3) The client presents a physical danger to self or others or has intent to commit a crime. (4) The therapist is ordered by the court to release information. (5) Parents of a minor can have access to records. (6) The client failed to pay for services rendered. Only information necessary to proceed with legal measures against such clients will be released to court authorities or collection agencies. (7) Other health care operations involved with treatment or payment may receive pertinent information as described in Notice of Privacy Practices.

EMERGENCIES: In the event of an emergency that may require my assistant but I am unavailable please leave a message. 989.488.7449. I will make every effort to return your call. If you have an emergency and cannot wait for a return call you should do one of the following. (1) Dial 911 for emergency medical attention or other emergency situations. (2) Go to the nearest emergency room. (3) Call you medical doctor or psychiatrist.

I hereby give **consent** for Jennifer Rapanos, LMSW to provide psychological, developmental and educational services including treatment and consultation for:

Client Name Date

Client/Parent/Guardian Signature Date

If seeking payment or reimbursement from a third-party payer (e.g., health insurance) such payers might request disclosure of pertinent information during the course of treatment. Do you authorize release of necessary information to third-party payers in order to bill insurance? (please circle one)

- ☐ Yes
- ☐ No
- ☐ Not Applicable

Client/Parent/Guardian Signature Date

I understand that I am responsible for any health insurance deductibles and coinsurance and that any amounts not paid by insurance is my responsibility. If this account is delinquent, I agree to pay all expenses, along with any court costs and actual attorney fees incurred in collecting this account.

Signature of Client/Parent/Guardian Signature Date