Hagerstown Counseling, LLC

5 Public Square, Suite# 404 S. Potomac St., Hagerstown, MD 21740

INFORMED CONSENT

Thank you for choosing Hagerstown Counseling, LLC for your counseling needs. We realize that starting counseling is a major decision and you may have many questions. This document is intended to inform you of our policies, State and Federal Laws and your rights. If you have other questions or concerns, please ask and we will try our best to give you all the information you need. Treatment practices, philosophy and plan imitations and risks will be discussed with you today.

CONFIDENTIALITY AND EMERGENCY SITUATIONS: Your verbal communication and clinical records are strictly confidential except for: a) information (diagnosis and dates of service) shared with your insurance company to process your claims, b) information you and/or your child or children report about physical, sexual abuse or elder abuse; then, by Maryland State Law, I am obligated to report this to the Department of Social Services, c) where you sign a release of information to have specific information shared d) if you provide information that informs me that you are in danger of harming yourself or others e) information necessary for case supervision or consultation and f) or when required by law. If an emergency situation for which the client or their guardian feels immediate attention is necessary, please contact the emergency services in the community (911) for those services. Hagerstown Counseling, LLC will follow those emergency services with standard counseling and support to the client or the client's family. E-mail, text messages and social networking sites are not confidential and we may not be able to respond.

Signature(s)_____Date:_____

FINANCIAL/INSURANCE ISSUES: As a courtesy we will bill your insurance company, HMO, responsible party or third party payer for you if you wish. We ask that at each session you pay your co-pay or 50% of the fee. In the event you have not met your deductible, the full fee is due at each session until the deductible is satisfied. If your insurance company denies payment or does not cover counseling, we request that you pay the balance due at that time. If your balance exceeds $250.00 we will need to ask that you pay for services when rendered. We ask that every client authorize payment of medical benefits directly to Hagerstown Counseling, LLC. **Current fees are $135 for intake and $95 for therapy sessions.**

Lastly, if you need to cancel or reschedule an appointment, please give 48 business hours advance notice, otherwise you will be billed at the hourly rate (except for Medicaid patient or where prohibited). Insurance companies will not pay for missed appointments, and you will be responsible for the full rate (not just your copay). We sincerely appreciate your cooperation and at any time you have any questions regarding insurance, fees, balances or payments please feel free to ask. **You may have a copy of this form if requested.**

Signature(s)_____Date_____

COORDINATION OF TREAMENT: It is important that all health care providers work together. As such, we would like your permission to communicate with your primary care physician and/or psychiatrist. **Please understand that you have the right to revoke this authorization, in writing, at any time by sending notice. However, a revocation is not valid to the extent that we have acted in reliance on such authorization**. If you prefer to decline consent no information will be shared.

____You may inform my physician(s) ____I decline to inform my physician

PHYSICIAN NAME:_____
CLINIC:_____
ADDRESS:_____
PHONE:_____

Signature(s)_____Date_____

NOTICE OF PRIVACY PRACTICES AND CLIENT RIGHTS: I/We have been offered and read a copy of the Notice of Privacy Practices and Client Rights document.

Signature(s)_____Date_____

Where may we contact you? Home, Work, Cell, Email, Other: _____

NEW CLIENT AGREEMENT: I/ We have read and received a copy of the New Client Agreement. I have discussed any points I did not understand, and have had any questions fully answered. I agree to act according to the points covered in the New Client Agreement. I understand that no specific promises have been made to me by this therapist about the results of treatment, the effectiveness of procedures used by this therapist, or the number of sessions necessary for therapy to be effective. I hereby agree to enter into therapy with Hagerstown Counseling, LLC and to cooperate fully and to the best of my ability, as shown by my signature here.

Signature(s)_____Date_____

EMERGENCY CONTACT: Who may we contact in case of emergency?

Name: _____ Phone: _____ Relation: _____

Name: _____ Phone: _____ Relation: _____

CONSENT FOR TREATMENT OF CHILDREN OR ADOLESCENTS:

I/We consent that _____ may be treated as a client at Hagerstown Counseling, LLC. It is understood that children over the age of 12 have confidentiality protected by law. At times it may be necessary to schedule appointments during school hours. We ask for your cooperation to provide the most timely treatment for you and your children. This consent to treat expires at the end of treatment or if revoked in writing.

Signature(s)_____Date_____