Acknowledgment of policies and full consents for Self Pay

Policy Consent for Self Pay

Tuesday, February 20, 2024 at 5:14 PM (EST)

Name of client

Date of birth

Email address

Phone number

Your signature on this form acknowledges that you are aware that the policies and full consents for Summit View Counseling, LLC (SVC) are available for your review at www.summitviewcounseling.com. By signing this form and by participating in services you accept the limitations of confidentiality, your financial responsibility and trust that Summit View Counseling and representatives are acting in good faith to provide professional and ethical services.
Further information is available on each policy listed below, Please initial that you have read or intend to read the policies available on website under "Getting Started, Client Forms"

Initial

PATIENT BILL OF RIGHTS
I recognize SVC has policies that recognize a client's right to be treated with respect and dignity.

Initial

HIPPA PRIVACY ACT
This Notice describes how Mental Health, Psychological and Medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Initial

INFORMED CONSENT / INFORMED CONSENT FOR CHILD/ADOLESCENT
This notice clarifies the limits of confidentiality in the cases of abuse, risk of harm to self or others and legal proceedings. In addition, Clients may be referred to other professionals and/or other levels of care/service to ensure most relevant care.

Initial

TELEHEALTH CONSENT
• Telehealth is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are located in two different locations.
• There are risks, benefits, and consequences associated with telehealth, including but not limited to, disruption of transmission by technology failures,

interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.

Initial

THERAPEUTIC / FINANCIAL CONTRACT

We will submit a bill to insurances that we participate with, however, you are ultimately responsible for payment if claim is denied or insurance is terminated. 24 hour notice is required for cancelled appointments.

***A $50 fee is rendered for first occasion. Future missed appointments will be charged the full amount of the session ($150, which is not covered by insurance)**.

In event of a mental health emergency, please contact the County crisis office – Lehigh County 610-782-3127 or Northampton County 610-252-9060 or go to the closest Emergency room. SVC Office emergency phone number is 215-813-9732.

Initial

APPOINTMENT REMINDERS

(1) If requested, appointment reminders are sent as a courtesy. Missed appointment fees may still apply, if, for any reason, the reminders cannot be delivered. (2) Appointment information may be classified as "Protected Health Information." By my signature, I am requesting that reminders be handled as I have noted.

Initial

"NO SUPRISES ACT"

I have read and reviewed the attached Good Faith Estimate of costs for treatment based on common services, length of services, issue, diagnosis and commitment to therapy. Frequency of sessions and treatment needs are made in conjunction with my therapist. By my signature, I am aware of the estimated costs associated with my treatment based on discounted out-of-pocket rates that I will owe.

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