HOOPER COUNSELING AND CONSULTATION SERVICES, LLC

Promoting Authenticity in Thinking, Doing, and Being

Consent to Treatment

CONSENT TO TREATMENT PURPOSE: "Provide psychotherapeutic services to those in need."

GOAL: "Improve mood, behaviors and general functioning toward a life worth living as defined by you, the client."

TECHNIQUE: "Evidence-Based and other researched therapy (counseling) techniques. Within the parameters of ethical and acceptable therapy practice, we have relationships with our clients that are real relationships between equals and will act in the client's best interest."

Depending on the type of evidence-based treatment, a client is offered access to their therapist on an as needed, on-call basis for purposes of skills coaching, crisis or suicide prevention, or relationship repair. On-call options include the use of texting toward this end. I understand the use of texting reduces the protection of my privacy as others may have access to my own text messaging. I will discuss with my therapist any concerns I may have with this mode of communication.

I am aware that the development and review of the process, or of a Treatment Plan, is in my best interest and may be required by governmental, funding, accrediting or other agencies and I agree to actively participate in this process.

I acknowledge I have received, read and understand the HIPAA form.

I am aware that the practice of psychotherapy or counseling is not an exact science, so predictions of the effects and effectiveness are neither precise nor guaranteed.

I acknowledge that no guarantees have been made to me regarding the results of treatment or procedures provided by Hooper Counseling and Consultation Services, LLC.

I am aware that my therapist may need to consult with authorized persons if necessary to discuss my treatment. I will be informed of this need, and provided the opportunity to deny this option, unless my therapist deems this necessary for preservation of life or protection from harm to self or others.

Telephone consultation is a mode of treatment employed for skills coaching, suicide protocols, relationship repair, or good news practice. It is not intended to replace emergency medical treatment if such treatment is deemed necessary. When this mode of treatment is offered, the therapist will do their best to answer within a reasonable time frame, but unforeseen circumstances or other determined contingencies may prevent prompt or timely reply. I understand that I am to reach out to emergency services if I engage in life-threatening behaviors, and that telephone consultation is not a life-saving service.

I may contact my therapist as the need arises at 517 999-0990 (office); 517204-4670 (cell). If the primary therapist is not available, you can contact the answering service at 517 372-2535. If this is a mental health emergency, please contact Community Mental Health Emergency Services (517)346-8200 or go to your local emergency room.

In the event of the loss of your therapist to death, leaving the practice, etc., your files will be reviewed and handled by a senior therapist designated:_____

I am aware that I may terminate my treatment at any time without consequence, but that I will still be responsible for payment for the services I had received.

I am aware that any cancellations of appointments must be made more than 24 hours in advance of the appointment and that if I do not cancel and do not show up I will be charged a cancellation fee.

I understand that the charge for a missed appointment is my responsibility and that my insurance company will not pay for this. I am aware that if I have not paid for services received, reach a cash balance of $350, and have not made payment arrangements, Hooper Counseling and Consultation Services, LLC may discontinue my treatment until arrangements are made for payment. I also understand that if I neglect to take care of any balance, outside collections services may be sought to collect the balance, and any additional fees will be assessed to my account.

I am aware that neither this office nor any therapist is responsible for any personal property or valuables I bring into its facilities. I acknowledge that, if I or anyone else for whom I am legally responsible, deliberately causes damage or steals any property of this office, I will be held financially responsible for its replacement.

In the event of a minor receiving services from Hooper Counseling and Consultation Services, LLC, I am aware documentation of legal custody and or guardianship may be required. Also, transportation of minors to and from this treatment facility is the responsibility of the legal guardians. Hooper Counseling and Consultation Services, LLC will not be responsible for any transportation issues or problems regarding minors.

I understand that if my minor child is receiving services, they are the primary client and as such hold the confidentiality of their therapist. I understand that information will not be automatically released to the parent or guardian, except as deemed necessary to secure the safety or well-being of the child or another identified person. I understand that if the minor child discloses information to their therapist of any type of abuse the therapist is mandated by law to report to an agency.

I understand that if I disclose to my therapist the intent to harm another person, or to end my life, that my therapist is mandated by law to take measures to inform appropriate authorities. I do hereby seek and consent to participate in treatment with Hooper Counseling and Consultation Services, LLC.

Insurance Payment and Policies:

If you have a health benefits policy, it may provide some coverage for mental health treatment. Please be aware that most insurance agreements require the therapist to provide a clinical diagnosis and sometimes additional clinical information such as a treatment plan or, in rare cases, a copy of the record. This information will become part of the insurance company records, as allowed by HIPAA guidelines.

I voluntarily give my permission for Hooper Counseling and Consultation Services, LLC to provide information to my insurance company to collect for professional services performed by my therapist. I am ultimately responsible, not by insurance company, for full payment to the fee to which we have agreed. Therefore, it is very important that you find out exactly what mental health services your policy covers. This includes services not covered by insurance, such as deductibles and co-payments. Your insurance company requires Hooper Counseling and Consultation Services, LLC to collect co-payments at the time of service; however, if you do accrue a balance, you will receive a statement at the beginning of each month.

There are several allowable forms of payments including cash, personal check, Visa, MasterCard, Discover and Debit cards. Payments can be made at the time of service or online using the website instamed at:

https://pay.instamed.com/midmimed7

The parent/guardian who authorizes treatment for an individual may be financially responsible. Any change in name, address, phone number or insurance information is the responsibility of the client or parent/guardian to inform the therapist.

Please note that Mid-Michigan Medical Management is the company utilized for billing. http://midmimed.com/ or 517 676-9788 if you have any questions. Please direct all inquiries first to your primary therapist.

Please initial and sign that you understand and have agreed to the policies and that you agree to receive treatment by the provider and sign below. I agree to accept 100% financial responsibility for this account.

_____ A 24-hour therapy notice is needed to cancel an appointment to avoid a $50 late charge.

_____ I have reviewed and been offered a copy of this Treatment Agreement.

_____ I have had the opportunity to review the HIPAA Guidelines (Health Insurance Portability and Accountability)

_____ I understand that Mid-Michigan Medical Management is the company utilized for billing.

_____ I understand the confidentiality guidelines

I certify, with my signature below, that I have read, had explained to me where necessary, fully understand, and agree with the contents of this Consent to Treatment.

Name of Client (Print):_____

_____

Client/Parent/Guardian Signature Client/Parent/Guardian Printed Name Date