SERENITY

BEHAVIORAL HEALTH SERVICES

Receipt of Understanding and Informed Consent for Treatment

Client Name: _____

Acknowledgment of receipt and understanding:

I certify that Serenity-BHS has provided me with a copy of the Client Welcome Packet which includes the cost of services, Client Rights and HIPPA policy. I have read and understand the following items. I have the ability to make decisions in regards to my own healthcare needs.

Cost of Services Policy:

Serenity-BHS Fee Policy is designed to ensure that you can utilize your health insurance as much as possible to cover the cost of services. Serenity BHS aims to provide adequate and effective counseling services to you and your family. Clients are responsible for the cost of all services provided by their therapist when insurance does not pay for such services due to deductible or other issues that may arise. **I agree to pay for the fees associated to the treatment services I am consenting to.**

I understand that my insurance company does not cover the cost of couples or family counseling. I understand that when I am having family or couples' counseling, that there is an additional $25 fee and this fee is in addition to my co-payment and/or deductible fees.

I understand the cost of group therapy is $50 per session.

Informed Consent for Treatment:

I give my consent for a diagnostic assessment. I understand that an assessment will include doing some paperwork during the first two sessions with my therapist. I also consent for treatment as outlined in my treatment plan that I will develop with my therapist within the first two sessions with my therapist. I understand that this consent is for the duration of the services to be provided. I understand that treatment will involve talking about my personal thoughts, feelings, and experiences. I understand that therapy may cause some additional stress or emotional difficulty during the course of learning how to resolve and address presenting problems. I understand that my therapist will help me process my feelings/thoughts during my sessions. I understand that if a crisis occurs as it relates to my mental health treatment, that I can contact Netcare Access for assistance at any time. I also understand that my therapist may ask to refer me to external medical services if they feel it is necessary to meet my therapeutic needs. Such referrals may include a medical or psychiatric assessment.

Cancellation Policy:

I understand that I need to give at least a 24-hour notice if I intend to cancel my therapy session in order to avoid paying the **cancellation fee of $50.00**. I understand that I have a right to terminate treatment at any time.

Communication Policy:

I consent to communications between myself and my therapist through the use of phone calls, emails and/or cell phone texting in order to schedule or re-schedule appointments. I understand that I should only communicate non-confidential information via email and texting with my therapists and that email and texting is not a form of treatment.

Confidentiality Policy:

I understand that my therapist and the staff of Serenity-BHS are committed to maintaining confidentiality. Please note that confidentiality will not be maintained in the event of the following:

1. Any threat to harm self or others, including murder, suicide, and assault.
2. Any reports of actual or suspected child abuse, endangerment or neglect.
3. Any reports, actual or suspected, of abuse of the elderly or dependent adult.
4. Clinician is court ordered to testify or a subpoena requires the release of such records to an attorney or investigator.
5. Guardian or legal custodial parent requests information.

HIPPA Policy: Your clinician may discuss cases with professional colleagues, without use of names, as deemed necessary. However, your therapist will always abide by the rules as outlined in our agency's policies, Ohio State Licensing Board rules, and will be compliant with HIPPA.

I agree to these policies and fees. I give consent for Serenity-BHS to bill me and/or my health insurance for the cost of my services. I also give consent to Serenity-BHS to send me a confidential Client Survey to get my feedback about the services I receive.

_____ _____

Signature of Client, Parent, or Legal Guardian Date