Front Street Clinic

Psychiatric & Psychological Services

Consent for Treatment and Limits of Liability

Limits of Services and Assumption of Risks

Therapy sessions carry both benefits and risks. Therapy sessions can significantly reduce the amount of distress someone is feeling, improve relationships, and/or resolve other specific issues. However, these improvements and any "cures" cannot be guaranteed for any condition due to the many variables that affect these therapy sessions. Experiencing uncomfortable feelings, discussing unpleasant situations and/or aspects of your life are considered risks of therapy sessions.

Limits of Confidentiality

What you discuss during your therapy session is kept confidential. No contents of the therapy sessions, whether verbal or written may be shared with another party without your written consent or the written consent of your legal guardian. The following is a list of exceptions:

Duty to Warn and Protect

If you disclose a plan or threat to harm yourself, the therapist must attempt to notify your family and notify legal authorities. In addition, if you disclose a plan to threat or harm another person, the therapist is required to warn the possible victim and notify legal authorities.

Abuse of Children and Vulnerable Adults

If you disclose, or it is suspected, that there is abuse or harmful neglect of children or vulnerable adults (i.e. the elderly, disabled/incompetent), the therapist must report this information to the appropriate state agency and/or legal authorities.

Prenatal Exposure to Controlled Substances

Therapists must report any admitted prenatal exposure to controlled substances that could be harmful to the mother or the child.

Minors/Guardianship

Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Insurance Providers

Insurance companies and other third-party payers are given information that they request regarding services to the clients.

The type of information that may be requested includes types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, summaries, etc.

By signing below, I agree to the above assumption of risk and limits of confidentiality and understand their meanings and ramifications.

Client Signature	Client Printed Name	Date

Front Street Clinic

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Payment and Billing Policies

AUTHORIZATION OF TREATMENT | ASSIGNMENT OF BENEFITS | RELEASE OF INFORMATION | PRIVACY NOTICE

CREDIT CARD & BILLING POLICIES.

Front Street Clinic requests that all clients provide a debit or credit card to keep on file in our secure electronic medical records program.

I hereby authorize **Front Street Clinic** to run my credit card on file for any balance I accrue after my insurance has processed my claims. I also authorize FSC to run my card for all private pay services and or any fee that may occur due to absence or no show.

I understand that my card will be run without prior notice to myself, unless otherwise specified and that a receipt will be provided via email. If you wish to terminate my credit card payment on file, I understand that I will need to give five (5) business days' notice for this to take effect.

Fees are due at time of service. If indicated, our billing department, may charge your credit card for your copay or fee owed following your date of service and will collect coinsurance and deductible payments from the card on file at the time your insurance responds to our claim and has determined the exact portion owed by the client. Clients are responsible for tracking this claim and the amount due by carefully reviewing the Explanation of Benefits (EOB) mailed or emailed directly to the client by the insurance company. Clients will receive a monthly statement via email.

Clients have a right to receive a statement of all charges, payments and balances associated with their account. A client who wishes to change their credit card on file may do so by notifying their provider to request a form to update the credit card number on file.

A client who wishes to cancel a card on file must do so in writing, 5 business days prior to the date on which they wish the change to take effect.

Insurance: We participate in most insurance plans. If you are not insured by a plan, we do business with, payment in full is expected at each visit. If you are insured by a plan, we do business with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

Co-payments and deductibles: All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

Non-covered services: Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by your insurance company. You must pay for these services in full at the time of visit.

Payment and Billing Policies (Continued)

Proof of insurance: All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

Claims submission: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

Coverage changes: If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. I f your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

Service Fees & Payments

Private Pay: In return for a fee listed below you will be provided with a comprehensive evaluation and assessment to determine both diagnostics and indications for course of treatment.

- Psychiatric Evaluation: $ 250.00
- Psychiatric Follow-up: $ 125.00
- Psychological Evaluation: $ 250.00
- Psychological Follow-up: $ 125.00
- Psychological Testing: $ 800.00
- Psychological Testing Feedback: $ 125.00
- No show or late cancellation fee: $ 125.00

The fee for each session will be due and must be paid at the beginning of each session. Acceptable forms of payment include cash, credit or debit cards, HSA and checks.

Any and all additional fees deemed the patient's responsibility at any time must be paid within 30 days of service or notification of balance. If you become involved in legal proceedings, you will be expected to pay for our clinician's professional time even if called to testify by another party. Because of the difficulty of legal involvement, you will be charged $500.00/hour for preparation, transportation, waiting time and attendance at any legal proceeding.

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Payment and Billing Policies (Continued)

AUTHORIZATION OF TREATMENT | ASSIGNMENT OF BENEFITS | RELEASE OF INFORMATION | PRIVACY NOTICE

Cancellations & Missed Appointments: In the event that you will not be able to keep an appointment, please notify the Clinic at least 48 hours in advance at (360) 697-1141 to avoid a full session charge, "no-show" fee. Full session fees for follow ups are $125, and $250 for Initial evaluations. Private therapy full session fee is $125. You will be charged a full session fee if a no show occurs. Please note all voices messages are time and date stamped. Appointments cancelled 24 hours in advance will not be charged a session fee. Arrival greater than 10 minutes after scheduled appointment time is considered a no show and will be charged a no-show fee and rescheduled. More than 3 cancellations/no shows, 24 hours or less may result in termination of therapeutic services.

Nonpayment: If your account is over 90 days past due, you will receive a letter stating that you have 30 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you, and your immediate family members, may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30- day period, our physician will only be able to treat you on an emergency basis.

Authorization to Release Information: I understand that Front Street Clinic will maintain records of my contacts for services and in general no information will be released without my specific written consent. I am aware, however, that information concerning my treatment and services rendered may be released as necessary to receive reimbursement by public and private health insurance plans. I authorize Front Street Clinic to release any medical/psychiatric/psychological information necessary for the processing of claims. I permit a copy of this authorization to be used in place of the original. I request that payment under my medical insurance be made directly to Front Street Clinic. I understand I am responsible for charges not paid by my insurance carrier.

By signing this form, I certify:

All responsible parties have reviewed this document to include patient, and or parent/legal guardian of minor patient. My electronic signature indicates that I understand and agree to pay for services as outlined in this agreement.

I HAVE READ THE FINANCIAL POLICY (ABOVE). I UNDERSTAND AND AGREE TO THIS FINANCIAL POLICY.

_____	_____	_____
Client Signature	Client Printed Name	Date

Cancellation Policy

If you are unable to attend an appointment, we request that you provide at least 24 hours advanced notice to our office. Since we are unable to use this time for another client, please note that you will be billed for the entire cost of your scheduled appointment if it is not timely cancelled, unless such cancellation is due to illness or an emergency. For cancellations made with less than 48-hour notice (unless due to illness or an emergency) or a scheduled appointment that is completely missed, you will be mailed a bill directly for the full session fee. We appreciate your help in keeping the office schedule running timely and efficiently.

By signing this form, I certify:

By my signature below, I acknowledge that I have read and understand the above and have been given the opportunity to ask questions. I confirm that I am the patient, or the patient's duly authorized representative and by Signing Below, I acknowledge receipt, understanding, and agreement with the cancellation policy.

_____	_____	_____
Client Signature	Client Printed Name	Date