# Treatment Consent Form
## Footsteps Christian Counseling Center

**Consent for Care and Treatment**

I, the undersigned, do herby agree and give my consent to care and treatment for authorized personnel of **Footsteps Counseling Center** to furnish mental health care and treatment to _____ (patient name) as may be considered necessary.

- I understand that like the other healing arts, psychotherapy is not an exact science and that no guarantees are being made as to the results of evaluation or treatment.
- I am aware that I am an active participant in this process and that I share the responsibility for the treatment process, including goal setting and termination.
- I understand that our work will be kept confidential with the exception of legal limitations on confidentiality. In addition, I am aware that, although my therapist is a clinically independent practitioner, consultations with associates are at times clinically advisable and my signature below gives my therapist permission to do that. The associates also provide emergency coverage for each other and that an associate providing coverage for my therapist may need access to relevant information to provide the best interim care possible.
- A list of patient rights and responsibilities is available upon request to all patients.
- I understand that per Virginia State law, Footsteps Counseling Center is required to maintain a medical record that will be kept for 10 years after last date of contact.
- I have the right to revoke this consent in writing and terminate services with my counselor and this center at any time. In that event, Footsteps Counseling staff is willing to help me locate alternative resources in the community.

**HIPAA Policy**

Footsteps Counseling Center uses your personal and health information for treatment, obtaining payment for treatment, conducting internal administrative activities, and assessing the quality of the care we are proud to provide. We have prepared a detailed NOTICE OF PRIVACY PRACTICES which is available to you at any time and is posted in our office. If any changes are made to our privacy and confidentiality policies, the current notice will always be posted for public view and copies will be available for distribution.

I, the undersigned, acknowledge that the formal office HIPPA policy and procedures have been explained to me and that a copy of the policy was made available to me.

**Financial Policy Statement**

At the time of or prior to initial service, we will contact your insurance company to verify coverage and to determine your co-pay/coinsurance and deductible amounts. While we will take all reasonable action to provide accurate mental health benefit information for your specific plan, be aware that verification of benefits is not a guarantee of payment from your insurance carrier. If your policy stipulates that you are responsible for a deductive and/or co-insurance payment, Footsteps Counseling Center is contractually obligated to collect those payments at the time of service. Additionally, if your plan requires a referral or preauthorization, it is your responsibility to obtain this. We will make every reasonable effort to assist you in this process.

___ **Primary Insurance** – We will bill your primary insurance as a courtesy to you. We will also bill your secondary insurance, if you have one. **All co-pays and deductibles are due at time of service**. Any remaining balance after your co-pay and your primary coverage has been paid is due from you upon receipt of the explanation of benefits from your primary insurance carrier. You will be responsible for any item not paid in full by your insurance carrier.

____**Self Pay –** Please pay the balance in full at the time of service, unless payment arrangements have been made with the intake coordinator or billing/office manager. Please be advised that Footsteps Counseling Center is not a credit grantor, and therefore, failure to maintain these arrangements may result in the placement of your account with a collection agency or attorney for collection.

****Third Party Reimbursement** – we will make every reasonable attempt to bill designated carrier. However, you are financially responsible for all charges if your carrier denies coverage. If payment is made directly to you, you are responsible for payment within 30 days.

**If any counselor employed by Footsteps Counseling Center is subpoenaed to appear in court, there will be charged $150.00 per hour, with a 1 hour minimum charge for the court appearance.**

I, the undersigned, understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collections agency fees, and attorney fees. Please submit claims to my insurance if indicated above.

**Patient Signature**_____ **Date**_____

**Witness** _____ **Date**_____

**Release of Information for PCP**

In order to provide the best care possible, your counselor would like to be able to communicate with your Primary Care Physician. This is often a mandate by certain managed care organizations.

Please check one: _____ I do _____I do not give Footsteps permission to exchange my protected health information with my PCP.

_____ Date _____

Signature of Patient or Guardian Name of Primary Care Physician

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