Patient ID: _____

PSYCHIATRIC SERVICES, S.C.
INFORMED CONSENT

As an individual receiving treatment at PSSC, you are being provided with information about fees, confidentiality, information disclosure procedures, individual rights and the grievance procedure you can use if you believe your rights are being violated. In addition we would like to provide you with information about the treatment you will receive.

- You will be served by one or more clinicians in the following mental health disciplines: social work, psychology or psychiatry. You may receive talk therapy, medication, psychological testing or a combination of these.
- Your first visit is a time to determine whether there is a good fit between you and your clinician(s). Assuming that there is a good fit, you and your clinician(s) will develop a treatment plan that involves active participation on both parts. The treatment plan outlines treatment goals and methods that may change over time.
- Treatment consists of meeting with you (or your child) individually, as a family or with you and a partner. In some cases you will also be referred to providers outside our clinic.
- Treatment does have some risks. Some individuals experience side effects with medication and may require more than one medication trial to achieve symptom management. Persons in treatment may also experience strong emotions (fear, sadness, anger) as they recall and discuss uncomfortable material.
- For most people the benefits of treatment outweigh the risks. Potential benefits include an increase in emotional stability, improved thinking and problem solving skills, healthier relationships and the ability to attain personal goals.
- Failure to receive treatment can result in increased symptom intensity and frequency and a worsening condition
- Mental health treatment at PSSC involves a professional relationship that exists for the benefit of the individual undergoing treatment. Gift giving and bartering which benefit the treating professional are not a part of the treatment relationship.
- All interactions with clinicians and support staff at PSSC are confidential. Information in written or verbal form cannot be released without your signed consent. Exceptions include situations that we are legally mandated to address that involve harm to yourself or someone else or a court order from a judge.
- Emergency services are provided by our clinic, should an emergency situation occur between appointments. You can call your clinician during office hours to schedule an earlier appointment or telephone contact. Outside of office hours PSSC maintains an answering service 24 hours per day which will contact your clinician or the on-call clinician(s). In life or death situations, 911 must be called.
- Treatment proceeds successfully when you and your clinician collaborate and treat each other respectfully. When this is absent, as evidenced by a pattern of non-adherence to a treatment plan, repeated missed appointments or lateness, or threatening or abusive behavior in our office, your clinician may decide to terminate treatment.

Signing this Informed Consent Form indicates my understanding of the above and my willingness to voluntarily participate in the treatment process. I understand also that I can rescind this agreement at any time, in writing.

This Informed Consent is valid for the duration of treatment with this provider.

Patient (or guardian) signature: _____ Date: _____

Clinician: _____ Date: _____

March 2020

PSYCHIATRIC SERVICES, S.C. BILLING INFORMATION

Medical Service (MD/APNP)		**Therapist Services (PhD/LSCW)**	
Initial Evaluations	$230 - $455	Initial Evaluations	$225-$250
Evaluation & Management (E&M)	$75 - $260	Group Therapy	$60
Psychotherapy without E&M	$100 - $240	Psychotherapy	$110 - $250
Psychotherapy with E&M	$100 – $160	Crisis Therapy	$225 - $250
Review of Medical Records	$80 - $100	Interactive Complexity	$25 - $50
Other Services Not Listed: _____		Other Services Not Listed: _____	

Please discuss with provider to obtain exact charge for your service.

The following services WILL NOT be covered by insurance and I WILL be personally responsible:

Telephone Conversations	$0 - $250	Missed Appointments or Late Cancellation	$0 - $250

I understand that I am personally responsible for missed appointments that have NOT been cancelled a minimum of 24 business hours in advance. This policy applies to my family members and me. I am aware if I have a problem attending scheduled appointments or late cancel I may no longer be eligible for services here.

The above fees were effective March 1, 2020 and may be subject to change. Our billing staff is able to provide you updated information at your request.

I will be the financially responsible party for services rendered at PSSC until the account balance is resolved, or until written appointment of another responsible party is agreed upon and signed.

I have read the **Psychiatric Services, S.C. Billing Information** and I understand that receiving services from Psychiatric Services, S.C. constitutes prior agreement to pay fees in full, including charges rejected by my insurance carrier as a result of their determination that the charge is above "usual and customary", "applied to deductible", "denied over maximum benefit" and/or "all patient copayments or co-insurance".

Patient or Responsible Party Signature: _____ Date: _____

Assignment of Insurance Benefits

Assignment of benefits: I hereby authorize Psychiatric Services, S.C. to release any medical information necessary to process any insurance claims. I further authorize my insurance carrier(s) to make payment directly to the provider for the benefits herein and otherwise payable to me.

Patient or Responsible Party Signature: _____ Date: _____