Psychological Services of Central Illinois, P.C. (P.S.C.I.)
Informed Consent for Treatment

Patient Name:_____ **Patient Date of Birth:**_____

Thank you for choosing Psychological Services of Central Illinois for your psychotherapy needs. The following is intended to help you understand the services we offer, as well as the nature of the professional relationship, and to give you an opportunity to ask any questions you have about our treatment services.

PSYCHOTHERAPY SERVICES

Psychotherapy is an active process in which you work with your therapist to identify your specific concerns and your goals for addressing those concerns. The therapist then collaborates with you on a variety of techniques and approaches to help you achieve those goals. Psychotherapy can have benefits and risks. You may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, or helplessness as you describe and work through your problems. However, psychotherapy can also lead to better relationships, solutions to specific problems, and significant reductions in feelings of distress. It will be important to inform your therapist about your feelings about therapy and approaches that work or do not work. Your therapist can help you find approaches that are most effective for you.

EVALUATION SERVICES

The goal of a psychological/neuropsychological evaluation is to help you, your treating providers, and qualified third parties (with your written consent) gain a better understanding of your relative strengths or weaknesses, specific diagnostic considerations, and treatment recommendations. The evaluation will start with a comprehensive clinical interview in which extensive background and personal history information will be obtained by the psychologist. Supplementary records from treating physicians, hospitals, schools, as well as interviews with designated family and/or friends, may be reviewed (with your consent). The evaluation will likely also involve testing. In case of a psychological evaluation, testing will likely be relatively brief and involve your completion of true-false and self-report emotion, coping, and personality questionnaires. In the case of a neuropsychological evaluation, the psychologist will evaluate your relative strengths and weaknesses by using tests designed to evaluate brain-behavior relationships and include measures of language, attention, memory, abstract reasoning, spatial-perceptual organization, and visuomotor skills. A neuropsychological evaluation also involves your completion of questionnaires assessing your emotions, coping, and personality. At the time of your appointment, the psychologist will review the evaluation process with you and what you can expect, as well as answer any questions you may have prior to initiating the evaluation.

CONFIDENTIALITY AND EMERGENCY SITUATIONS

The information we collect from you is confidential. Information can only be disclosed to individuals/organizations if you provide written permission for disclosure or as stipulated by the Illinois Department of Mental Health and Developmental Disabilities Confidentiality Act. Please note the following exceptions to confidentiality of your verbal communication and clinical records:

- To provide information (diagnosis, dates of service, etc.) to your insurance company to process your claims;
- To report information given by you, family members, and/or your child or children regarding physical, sexual, or elder abuse. We are obligated by Illinois State Law to report this information to the appropriate agency;
- When you sign a release of information form to allow us to share specific information with other individuals, agencies, etc.;
- If you, your child, or a family member inform our psychologists or staff members that they are in danger of harming themselves or others;
- When that information is necessary for consultation within the Psychological Services of Central Illinois clinic;

- or where required by law.

FEES AND INSURANCE INFORMATION

We do accept insurance as a form of payment, and we are on a number of insurance panels to provide in-network care to patients with a variety of common plans in the area. To see if we are a provider for your insurance, feel free to contact the office or call the customer service number on the back of your insurance card. As a courtesy, we will bill your insurance for you. However, you are ultimately responsible for any amounts incurred, and having insurance does not release you from this obligation. It is your responsibility to maintain a copy of your current insurance card and information on file with the office. Incorrect/missing insurance information may result in payment delays and/or claim denials which could increase your out-of-pocket cost.

Payment for therapy/counseling services are expected on the date services are rendered, unless other arrangements are made in advance. You will be expected to pay any copays and deductible and/or coinsurance due on that date (when that amount is able to be determined). For psychological or neuropsychological testing, a bill will be sent to you upon completion of the evaluation process for any remainder due once any insurance payments have been processed. It is your responsibility as the patient to ensure that we have your current contact information on file, including your current address and phone number. Failure to maintain current contact information with the office does not release you from your obligation to pay for any services provided by Psychological Services of Central Illinois that your insurance does not cover.

ATTENDANCE AND PUNCTUALITY

Psychotherapy and evaluation services are involved processes which require a significant time commitment from both patient and psychologist/counselor. We have the expectation that you will present for your scheduled appointment on time. If you are running late for your appointment, please let us know as soon as possible. Unfortunately, due to our commitment to our other patients, we are unable to extend the ending time of a session to compensate for a late arrival. If you are not able to arrive within fifteen minutes of your scheduled start time, your assigned practitioner may require you to reschedule your appointment.

If you are unable to keep your appointment, please provide a minimum of 24 hours advance notice to the office. Late cancellations or “no-shows” waste limited clinical time that could be used to assist other patients. Patients who “no-show” for an appointment may be charged the full amount for the session at the discretion of the psychologist. This amount is not billable to insurance and payment is the sole responsibility of the patient. Patients who demonstrate a pattern of repeated missed appointments may be placed on an alternate scheduling plan. Extensive “no-shows” may result in the patient becoming ineligible for further services at Psychological Services of Central Illinois.

COMPLETION/TERMINATION OF SERVICES

Therapy typically ends when you and your assigned therapist determine that you have accomplished your treatment objectives and are no longer in need of therapy services. This is a process that is generally completed together with the input of your assigned therapist. However, if you discontinue services without consulting your therapist, we will attempt to contact you at approximately 4 months after your last date of service to ensure you are doing well. If you are not in need of services at that time or if we are unable to reach you, we will proceed with closing your file. A closed file does not prevent you from accessing services again in the future if the need arises. You may contact the office at any time to request further services if needed.

CONSENT FOR TELETHERAPY SERVICES

In some cases, virtual appointments (also known as teletherapy) may be available as an alternative to in-office visits. Teletherapy visits are only available in the following circumstances:

1. Therapy services only – unfortunately, we are not able to offer virtual appointments for psychological or neuropsychological testing or feedback sessions.
2. Where insurance has agreed to cover teletherapy sessions, or you have agreed to cover this service out-of-pocket. This will vary according to the specific insurance policy you have. It is your responsibility as the patient to verify if your plan covers teletherapy services. The best way to find this out is to call the customer service number on the back of your insurance card and ask if teletherapy services are covered for mental health visits.
3. Where deemed clinically appropriate by your assigned therapist.

I understand I have a right to confidentiality with teletherapy under the same laws that protect the confidentiality of my personal and health information for in-person psychotherapy. Any information disclosed by me during the course of remote teletherapy is confidential.

I understand that there are unique risks specific to teletherapy services including, but not limited to, the possibility of disruption, distortion or unauthorized access during transmission of personal information due to internet/electronic/technical failures beyond the psychologist's control. The www.doxy.me telemedicine video conferencing platform is HIPAA compliant for privacy/security and will be used during my teletherapy appointment.

I understand that I may not benefit from teletherapy and that teletherapy may be discontinued in favor of another treatment modality, therapeutic strategy or termination of treatment. Should I find myself in need of emergency mental health care, I understand that I can call 911 or proceed to the nearest hospital emergency room.

I understand that I am solely responsible for the privacy and confidentiality in my surrounding environment while engaged in teletherapy and will exercise appropriate privacy measures. I also understand that I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.

Please initial <u>ONLY</u> if you consent to participate in teletherapy services:

_____ *I understand the potential risks and benefits of participating in teletherapy services. I consent to participate in virtual services with all the provisions outlined above, provided my therapist and I determine that it is an appropriate course of treatment for me.*

CONSENT FOR TREATMENT

I agree and consent to participate in psychological evaluation and/or treatment services offered and provided at Psychological Services of Central Illinois. I understand that I am consenting and agreeing only to those services that my assigned provider is qualified to provide within the scope of the provider's license, certification, and training. If the patient is under the age of eighteen or unable to consent to treatment, I attest that I have legal custody of this individual and am authorized to initiate and consent for treatment and/or legally authorized to initiate and consent to treatment on behalf of this individual. I have received and had an opportunity to review the clinic's *Explanation of Policies and Procedures.*

I have received a copy of Psychological Services of Central Illinois' Notice of Privacy Practices and have been given an opportunity to ask questions about the information contained within.

I consent to have information released to my insurance company for the purposes of billing my insurance and to have any payments forwarded directly to Psychological Services of Central Illinois. I further understand that I am ultimately responsible for payment due for any services rendered and that having health insurance does not release me from this obligation.

I understand that any amount due towards my insurance deductible and/or any applicable copays and/or coinsurance are due at the time services are rendered unless other arrangements have been made in advance.

I understand that if I “no-show” for an appointment or if I fail to give 24 hours advance notice of cancellation, I may be charged the full amount for the session, and this amount is not billable to my insurance. I further understand that repeated “no-shows” may result in my being placed on an alternate scheduling plan or becoming ineligible for further services.

Signature of adult patient, parent, or guardian	Date
Signature of child (if 12 years old or older)	Date
Signature of witness	Date