Gulf Coast Psychology

5290 Summerlin Commons Way, Suite 1002, Fort Myers, FL 33907
Phone 239-274-7792 / Fax 239-247-5344

Informed Consent for Financial Responsibility & Psychological Services

Introduction

Welcome to my practice. Please take a moment to read through this important information. It is intended to inform you of the conditions regarding the psychological services you are requesting. It is our policy to clarify all financial matters before services are rendered, particularly when it comes to insurance coverage. Please understand that the information given to you by your insurance carrier is not a guarantee of payment or coverage.

Financial Responsibility

I understand and agree that I will be charged a fee for all direct and indirect professional services rendered on my behalf. The standard hourly rate for clinical services is $185.00. Billable services may include, but are not limited to any and all of the following: Direct (face-to-face) therapeutic services, clinical interviews, behavioral observations, psychological testing or consultation services. More limited or extended services will be billed on a prorated basis. Phone calls initiated by or for the patient will be billed at the standard professional fee, based on the amount of time spent; there will be no charge for phone calls less than five (5) minutes in duration. Initial:_____

Self-Pay Option

When filing with insurance, all information necessary to process a claim is no longer under your control. This could include information that you don't want your insurance carrier to know, as insurance payment is contingent upon a DSM-5 psychiatric diagnosis. This information becomes part of your medical record with your insurance carrier. If confidentiality is important to you, you may choose to pay for your own psychological care rather than submit claims to your insurance company. Please inform our office staff if you would prefer this option.

Testing

Psychological testing is sometimes necessary and can be extremely helpful in understanding the nature and extent of academic, learning, emotional and/or psychological difficulties. Evaluations usually require five to ten hours of testing. For every hour of direct testing, another hour is needed for scoring, analyzing and interpreting the results. The hourly rate for psychological evaluation is $185.00. In addition to verbal feedback, an optional comprehensive report can be prepared at your request. In our experience, insurance carriers do not cover this comprehensive report and therefore, the patient is responsible for this cost. When the release of the report is required quickly (i.e. prior to our receipt of payment by the insurance company) a $250 deposit is required. This deposit is then refunded in part or in full at the time payment is received by our office from the insurance carrier. Initial:_____

Cancellations and Check Returns

Gulf Coast Psychology requires a 24-hour notice for appointment cancellations. If you are cancelling without a 24-hour notice you will be charged for the time at the rate of $140/hr missed. Insurance will not cover cancellation charges. Cancellation fees must be paid before another appointment can be scheduled.

For returned checks, you will be charged $25.00 plus the fee currently charged by our banking institution. Restitution must be made in cash.

Consent for Psychological Services

I hereby voluntarily give my consent to psychological services provided by Gulf Coast Psychology, Inc. The consent applies to myself, my child, and/or my family. Because I have the right to refuse services at any time, I understand and agree that my continued participation implies informed consent.

Limitations of Services

Gulf Coast Psychology, Inc. provides outpatient psychological services only. Gulf Coast Psychology, Inc. does not provide emergency services. Should you require emergency services after hours, please dial 911.

Assumptions of Risks

I understand that the potential benefits of undergoing psychological services may include improvement in psychological functioning of myself or child and/or an increased understanding of myself and/or child. I understand that the potential risks may include possible disagreement with opinions offered to me, and possible emotional distress concerning my situation. I understand that alternative procedures include services provided by another psychologist, psychiatrist, or mental health professional.

I understand that while the evaluation and/or treatment will be based upon known psychological principles and research, the practice of psychology is not an exact science. I acknowledge that no guarantees have been made to me concerning the results of evaluation and/or treatment provided by Gulf Coast Psychology, Inc.

Acknowledgement of Responsibility

Payment is required at the time of service. In lieu of this, you will guarantee full payment with a credit card. In the event that you are entitled to benefits of any type arising out of any insurance policy, you hereby assign any insurance benefits to Gulf Coast Psychology, Inc. You will be responsible for payment of any charges that are not covered by insurance**.**

It is your responsibility to understand your insurance plan. Any precertification which is required by your insurance company must be done prior to your appointment. Initial:_____

It is difficult to understand all of the variances of each insurance company and you will be responsible for payments which are not covered by your insurance company. Any reimbursement issues are the responsibility of the client and the insurance company, not Gulf Coast Psychology, Inc. Initial:_____

Please provide the credit card information below. We do not accept Discover or American Express:

VISA MASTERCARD

Full name on card_____

Credit Card # _____

Expiration Date _____ Security Code _____

By signing below, you authorize Gulf Coast Psychology, Inc. to charge your credit or debit card for any unpaid balance after insurance discounts. If your insurance carrier does not pay within 30 days and you are notified by email or phone, your card will be charged for the unpaid balance.

Name of Client: _____Date: _____

Signature of Client or Parent/Guardian of Client:_____

Past due accounts may be turned over to an attorney or a collection agency, and the undersigned shall be liable for attorney's fees and/or collection agency's fees and expenses. Any patient having an outstanding balance that is referred to a collection agency will not be able to schedule until the balance is paid in full. Initial:_____

Release of Information

Communications may occur by phone or in writing with your insurer for the purpose of conducting utilization reviews. Utilization reviews may require the release of written or verbal confidential information such as progress notes, treatment reports and psychological reports. You are directing Gulf Coast Psychology, Inc. to exchange information regarding your case, including release of a psychological report to agencies, doctors, therapists, or to anyone you authorize in writing.

By authorizing release of information, I understand that I am waiving the confidential nature of the patient-psychologist relationship. I also authorize the release of information as necessary for the purpose of Gulf Coast Psychology, Inc. obtaining consultation regarding my evaluation and/or treatment. I authorize the release of any and all information requested by my insurance carrier for the purpose of processing my insurance claim and obtaining payment for services. In authorizing the release of information to any insurance company or other third parties, I understand that the information may become part of the third parties' records and that Gulf Coast Psychology, Inc. can no longer control any subsequent release of information. The only way you can absolutely assure the confidentiality of your treatment is to pay for the services yourself.

Limits of Confidentiality

I understand and agree that my disclosures and communications are considered privileged and confidential, except to the extent that I authorize a release of information. I understand that state law requires a psychologist to disclose the following without consent or authorization:

1. Known or reasonably suspected abuse or harmful neglect of children, the elderly, or disabled or incompetent individuals.
2. Immediate threats of physical violence against a readily identifiable victim.
3. An immediate threat of self-inflicted damage.
4. Also, where a patient or client, by alleging mental or emotional damages in litigation, puts his or her mental state at issue or files a malpractice claim, records may be released without consent or authorization. Where a patient is examined pursuant to a court order, confidentiality may not apply. Under such circumstances, I acknowledge that I hold Gulf Coast Psychology, Inc. harmless for releasing information under any of the above conditions.

Statement of Understanding

I certify that I have read this form or that it has been read and explained to me in terms of my understanding. My questions have been answered to my satisfaction and all statements of which I do not approve have been stricken by mutual agreement. I understand I may revoke this consent at any time except to the extent that action has been taken in reliance upon it. I understand that my consent for release of information will be considered valid for twelve (12) months after my last appointment. I acknowledge that I voluntarily consent to the preceding conditions. By signing this form, I understand and agree with the terms and conditions of this form.

_____

Name of Patient

_____ _____

Signature of Adult Patient or Parent/Guardian of Patient Date