April Nelson, LLC
6408 Constitution Drive Fort Wayne, IN 46804
(260) 459-3833 Fax: 260-459-0282

Consent for Services

Please initial and sign below consenting for treatment of mental health services.

_____ **Responsibility for Charges Incurred**

All insurance co-pays, co-insurance, and/or deductible amounts are due at the time of service. I agree that I am responsible for charges incurred after all insurance payments have been made. I understand I am responsible for the entire amount of services in the event I do not provide accurate information related to my insurance information. I understand that there is a $30.00 return check fee charge.

_____ **Agreement to Pay**

In consideration for the services rendered and to be rendered by April Nelson, LLC to the below mentioned patient, I agree to pay April Nelson, LLC for all services and charges in accordance with the terms and policies of April Nelson, LLC. I further agree and guarantee that in the event the account is not paid in accordance with the financial arrangements made or within sixty (60) days from the date of service and it is necessary to place this account in the hands of a collection agency, to pay cost of collections which includes: 35% of the outstanding balance, court costs, collection fees and interest from the date of demand.

_____ **Assignment of Payment**

I assign all treatment benefits which are due for services to April Nelson, LLC be paid directly to April Nelson, LLC.

_____ **Failed Appointment Charges**

I understand that 24 hour notice is required for cancellation of appointments. A failed or no show appointment is defined as a cancellation that is not done within 24 hours of the appointed time. I understand that if I fail to cancel my appointment within 24 hours or if I do not show for a scheduled appointment, I am responsible for the full $90.00 fee for the session, which will be due prior to the next scheduled appointment.

_____ **Treatment of Choice**

I understand that I have chosen to be involved in counseling services. I have the right to be actively involved in my treatment goals and can ask questions at any time. I understand that I may terminate treatment at any time.

_____ **Additional Fees**

I understand there will be a charge for any letters/summaries required during my care. This includes letters to schools, attorneys, and outside professionals. I understand fees for consultation to attorneys will occur, as well as for any court/legal involvement and related travel fees.

_____ **Release of Medical Information**

I authorize, April Nelson, LLC to release necessary medical information to the appropriate third parties for reimbursement purposes and/or persons authorized to conduct utilization review services.

I agree and consent to participate in services provided by April Nelson, LLC as defined by the laws of Indiana. I understand that I am consenting and agreeing to counseling services by a licensed counselor in the state of Indiana.

Patient Name if child:_____

Client/Responsible Party: _____ Date: _____

Witness: _____ Date: _____

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Patient Name: _____ **Gender:** __ **Male** __ **Female**

Address: _____
Street/Box# **City** **State** **Zip**

Home Phone: _____ **Permission to Contact/ Leave Message:** __ **Yes** __ **No** **Initials:** _____

Work Phone: _____ **Permission to Contact/ Leave Message:** __ **Yes** __ **No** **Initials:** _____

Cellular Phone: _____ **Permission to Contact/ Leave Message:** __ **Yes** __ **No** **Initials:** _____

Marital Status: __ **S** __ **M** __ **D** __ **W** **Patient Employer:** _____

Patient Date of Birth: _____ **Patient Age:** _____

Primary Care Physician: _____ **Permission to Contact Physician:** __ **Y** __ **N**

Primary Insurance Information

Insured's Name (if different from above): _____

Insured's Address: _____
Street/Box# **City** **State** **Zip**

Insured's Social Security #: _____ **Insured's Date of Birth:** _____

Insured's Employer: _____ **Relationship to Patient:** _____

Insurance Company: _____ **Insurance ID #:** _____ **Group #** _____

Secondary Insurance Information

Insured's Name (if different from above): _____

Insured's Address: _____

Insured's Social Security #: _____ **Insured's Date of Birth:** _____

Insured's Employer: _____ **Relationship to Patient:** _____

Insurance Company: _____ **Insurance ID #:** _____ **Group #** _____

If Child Is Identified Patient/ Client

Father's Name: _____ Step Father: _____

Mother's Name: _____ Step Mother: _____

Emergency Contact

Name: _____ Phone: _____ Relationship: _____

April Nelson, LLC

Authorization for Release/ Exchange of Information

Client Name: _____

Date of Birth:_____

Information Release/ Exchange From:
Facility: April Nelson, LLC
Address: 6408 Constitution Drive
Fort Wayne, IN 46804
p: (260) 459-3833 f: (260) 459-0282

Information Release/ Exchange to:
Facility/Person: _____
Address: _____
Fax: (___) _____
Phone :(____) _____

__Intake Education
__Assessment/diagnosis
__Compliance/ Attendance
__Medical Records
__Treatment Recommendations
__Attendance
__Treatment Plan
__Recommendations

__ Progress Notes
__ Progress Reports
__ Medical Tests
__ Psychological Evaluation
__ Psychiatric Evaluation
__ Treatment Prognosis
__ Discharge summary; prognosis
__Other (specify) _____

Purpose or need for such Release/ Exchange of Information:

_____

_____

Authorization to Release/Exchange Information:
I understand that this authorization shall remain in effect for 180 days from the date of my signature below, unless an earlier expiration date is specified in this space ( ). I also understand that except to the extent that action has already been taken based upon this authorization, I may revoke this consent at any time by written notification to this agency.

I hereby authorize the release and /or exchange of the above identifying information from my records. I hereby release April Nelson, LLC from all legal responsibility or liability that may arise from this authorization.

_____

Authorizing Person Signature: Date:

_____

Parent or Guardian Signature: Date:

_____

Witness/Clinician Signature: Date:

This information has been disclosed to you from the records protected by Federal Confidentiality Rules (42 CFR, Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of this person to whom it pertains or as otherwise permitted by 42CFR, part 2. A general authorization is not sufficient for this purpose. The federal rules restrict any of the information to criminally investigate or prosecute any alcohol or drug consumer.

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Cancellation Policy

Cancellations for scheduled appointments require a 24 Hour notice. If 24 hours is not given you will be charged the full session fee of $90.00. A no show for an appointment will result in a full session fee of $90.00.

Patient Name: _____

Responsible Party Signature :(if patient is a minor) _____ Date: _____

Witness: _____ Date: _____

Social Media Policy

FRIENDING

I cannot accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc.). I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy.

INTERACTING

Please do not use SMS (mobile phone text messaging) or messaging on Social Networking sites such as Twitter, Facebook, or LinkedIn to contact me. These sites are not secure and I may not read these messages in a timely fashion. Do not use Wall postings, @ replies, or other means of engaging with me this way could compromise your confidentiality. It may also create the possibility that these exchanges become a part of your legal medical record and will need to be documented and archived in your chart.

Please note that if you do choose to utilize SMS to communicate with me I cannot guarantee the confidentiality of these messages. If you do utilize SMS please do only for administrative reasons, such as to change or confirm an appointment.

If you need to contact me between sessions, the best way to do so is by phone (260-459-3833). Email is not set up to guarantee privacy of your personal medical record. If you choose to send information through email, please understand I cannot guarantee your privacy by HIPPA standards.

EMAIL

I prefer using my email only to arrange or modify appointments. Please do not email me content related to your therapy sessions, as email is not completely secure or confidential. If you choose to communicate with me by email, be aware that all emails are retained in the logs of you and my Internet service providers. While it is unlikely that someone will be looking at these logs, they are, in theory, available to be read by the system administrator(s) of the Internet service provider. You should also know that any emails I receive from you and any responses that I send to you become part of your legal record.

I have read and understand the social media policy.

_____ _____

Signature: Date:

_____ _____

Signature:/Witness Date:

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Telebehavioral Health Informed Consent

Introduction of Telebehavioral Health:

_____ As a patient receiving behavioral services through telebehavioral health technologies, I understand:

_____ Telebehavioral health is the delivery of behavioral health services using interactive technologies (use of audio, video or other electronic communications) between a practitioner and a client/patient who are not in the same physical location.

_____ The interactive technologies used in telebehavioral health incorporate network and software security protocols to protect the confidentiality of client/patient information transmitted via any electronic channel. These protocols include measures to safeguard the data and to aid in protecting against intentional or unintentional corruption.

Software Security Protocols:

_____ Electronic systems used will incorporate network and software security protocols to protect the privacy and security of health information and imaging data, and will include measures to safeguard the data to ensure its integrity against intentional or unintentional corruption.

Benefits & Limitations:

_____ This service is provided by technology (including but not limited to video, phone, text, apps and email) and may not involve direct face to face communication. There are benefits and limitations to this service.

Billing & Financial Responsibility:

_____ I understand all efforts will be made to bill my health insurance for telebehavioral health services. I understand I am responsible for charges incurred for the telebehavioral health services based on my insurance plan.

Technology Requirements:

_____ I will need access to, and familiarity with, the appropriate technology in order to participate in the service provided. My practitioner will inform me of the technology to be used and how I will enter the telebehavioral health session.

Exchange of Information:

_____ The exchange of information will not be direct and any paperwork exchanged will likely be provided through electronic means or through postal delivery.

_____ During my telebehavioral health session, details of my medical history and personal health information may be discussed with myself or other behavioral health care professionals through the use of interactive video, audio or other telecommunications technology.

Local Practitioners:

_____ If a need for direct, in-person services arises, it is my responsibility to contact my practitioner to determine the best course of action or I may contact Parkview Behavioral Health Assessment Center at (260) 373-7500, or St. Joseph Behavioral Health at (260) 425-3606. I also understand I can call 911 in emergency situations or proceed to my nearest emergency room.

Self-Termination:

_____ I may decline any telebehavioral health services at any time without jeopardizing my access to future care, services, and benefits.

Risks of Technology:

_____ These services rely on technology, which allows for greater convenience in service delivery. There are risks in transmitting information over technology that include, but are not limited to, breaches of confidentiality, theft of personal information, and disruption of service due to technical difficulties.

Modification Plan:

_____ My practitioner and I will regularly reassess the appropriateness of continuing to deliver services to me through the use of the technologies we have agreed upon today, and modify our plan as needed.

Emergency Protocol:

_____ In emergencies, in the event of disruption of service, or for routine or administrative reasons, it may be necessary to communicate by other means:

In emergency situations, practitioner should call _____

Disruption of Service:

_____ Should service be disrupted, practitioner should call _____

Practitioner Communication:

_____ My practitioner may utilize alternative means of communication in the following circumstances:

_____ Telebehavioral session was disrupted due to internet/technology failure of any form.

_____ Poor reception preventing effective communication.

Client Communication:

_____ It is my responsibility to maintain privacy on the patient end of communication. Insurance companies, those authorized by the patient, and those permitted by law may also have access to records or communications.

_____I agree I will not audio or video record the telebehavioral session.

Storage:
_____My communication exchanged with my practitioner will be documented by the practitioner in the form of a progress note placed in my medical record.

Laws & Standards:
_____ The laws and professional standards that apply to in-person behavioral services also apply to telehealth services. This document does not replace other agreements, contracts, or documentation of informed consent.

Confirmation of Agreement:

_____
Client Printed Name

_____ _____
Signature of Client or Legal Guardian Date

_____
Printed Name of Practitioner

_____ _____
Signature of Practitioner Date