# GROVE CITY
# PSYCHOLOGICAL SERVICES

## CONSENT TO TREATMENT

I, ________________________________________, give my permission and consent to Grove City Psychological Services, to provide psychological counseling to me and/or my child/spouse.

I understand that treatment with the therapist will almost always be confidential and a written release will be required to disclose information. I will be informed of my child's progress and given parent guidance sessions if not directly involved in family therapy. I understand that I will be involved in the development of my/my child's treatment plan, which will be reviewed regularly. I understand I have the right to discontinue treatment at any time. I understand that I have the responsibility to provide appropriate information in order for treatment to be appropriate and effective. I further understand that negative consequences may occur if I discontinue treatment against the advice of my therapist.

I further understand that the therapist, by law, must report actual or suspected child or elder abuse to the appropriate authorities. In addition, the therapist has a legal responsibility to protect anyone threatened with violence, harmful or dangerous actions (including myself) and may break the confidentiality of our communications if such a situation arise. I understand that the therapist will make a reasonable effort to resolve these situations before breaking confidentiality.

I understand that I am financially responsible for this treatment at a copay fee of $____________ per therapy hour as well as any yearly deductible amounts to be satisfied per my insurance plan provisions, and agree to make prompt payment for services. The contracted amount to be billed to your insurance company per visit is $____________.
I understand that if I am unable pay my copay, I will owe an additional $5.00 charge. I understand that appointments are to be cancelled 24 hours in advance or I will be responsible for a $50.00 payment for the missed session (insurance will not cover this).

I understand I am responsible for obtaining necessary insurance papers and confirming coverage. I acknowledge that although insurance papers and confirming coverage. I acknowledge that although insurance will be billed directly, I am ultimately responsible for payment. I consent to the disclosure of necessary information to my insurance company, which is required for billing (diagnosis, treatment plans and dates).

I have had the opportunity to discuss this consent with my therapist and do hereby give full voluntary consent to the treatment for myself and/or my family/child under the conditions set forth above.

________________________________________ ________________________________________

Signature Date

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## CONSENT TO USE/DISCLOSE HEALTH INFORMATION

This form is an agreement between you, ____________________________, and me/us: Grove City Psychological Services. When we use the word "you" below, it will mean your child, spouse, relative, or other person if you have written his or her name here ______________________________.

**Please read this before you sign this consent form.** When we examine, diagnose, treat, or refer you we will be collecting what the law calls Protected Health Information (PHI) about you. We need to use this information here to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others who provide treatment to you or need it to arrange payment for your treatment or for other business or government functions. By signing this form you are agreeing to let us use your information here and send it to others. The Notice of Privacy Practices explains in more detail your rights and how we can use and share your information.

**IMPORTANT: If you do not sign this consent form agreeing to what is in our Notice of Privacy Practices we cannot treat you.**

In the future, we may change how we use and share your information and so may change our Notice of Privacy Practices. If we do change it, you can get a copy by calling us at (614) 871-0035 or from our privacy officer, Dr. Jim Broyles.

If you are concerned about some of your information, you have the right to ask us not to share some of your information for treatment, payment, or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations. However, if we do agree, we promise to comply with your wish.

After you have signed this consent, you have the right to revoke it (by writing a letter telling us you no longer consent) and we will comply with your wishes about using or sharing your information from that time on but we may already have used or shared some of your information and cannot change that.

____________________________________ ____________________________________

Signature Date

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## CLIENT PAYMENT POLICY

Here in our practice, your well being is our highest priority, so we created a payment policy with our patients in mind. This payment policy prevents making a costly bill, which can be quite stressful. It also helps us bring costs down by minimizing unnecessary billing.

If you plan to use your health insurance to pay for our services, we will direct bill your insurance company. We only ask you to pay that portion of the cost which your insurance company does not pay. This is known as an "out of pocket expense." This might include any co-pay or deductible on your policy.

We ask you to please pay any out of pocket expense you owe at the time of your appointment, before you meet with your therapist. If you are unable to pay your out of pocket expense at that time, a $5.00 surcharge will be added to your account on that day.

We understand that some of our clients may be experiencing difficult financial circumstances. If you feel that you are unable to follow this policy, talk with your therapist, and he or she can make alternative arrangements with you.

___________________________________ ___________________________________

Signature Date

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## CLIENT MEDICAL INFORMATION

Client Name: _______________________________________________ Date: _____________
Date of Birth: _______________________ Age: ___________ Gender: Male___ Female___
Family Physician: ____________________________________________ Consent to contact: Yes___ No___
Current Medications/Dosage & Frequency: (include birth control pills and over the counter medications)
_____________________________________________________________________________________________________
_____________________________________________________________________________________________________
Medication Allergies and/or Side Effects: _____________________________________________________________
_____________________________________________________________________________________________________

Physical Concerns and/or Problems: (check if applicable to you or to a family member)

**GENERAL**
Patient/Family
☐/☐ concentration/memory problems
☐/☐ fatigue
☐/☐ nose bleeds
☐/☐ sleep difficulties/nightmares
☐/☐ dry mouth/difficulty swallowing
☐/☐ depression/weepiness
☐/☐ weight gain/loss
☐/☐ high energy
☐/☐ flushes/chills/hot flashes
☐/☐ skin rash/hives
☐/☐ anxiety/panic
☐/☐ fears/phobias
☐/☐ rituals
☐/☐ hallucinations

**CARDIOVASCULAR**
Patient/Family
☐/☐ blood pressure
☐/☐ heart disease
☐/☐ chest pains
☐/☐ palpitations

**NUTRITION**
Patient/Family
☐/☐ caffeine use (2+ cups a day)
☐/☐ alcohol/drug use
☐/☐ nicotine

**GASTROINTESTINAL**
Patient/Family
☐/☐ diarrhea
☐/☐ constipation
☐/☐ over-eating/under-eating
☐/☐ vomiting/nausea
☐/☐ ulcers

**NEUROMUSCULAR**
Patient/Family
☐/☐ headaches/migraines
☐/☐ back problems
☐/☐ tingling/numbness
☐/☐ tremors/tics/twitches
☐/☐ seizures
☐/☐ dizziness/light-headedness
☐/☐ loss of consciousness
☐/☐ difficulty in walking

(Continued on next page)

Physical Concerns and/or Problems: (check if applicable to you or to a family member)

**ENDOCRINE**
Patient/Family
☐/☐ thyroid
☐/☐ diabetes
☐/☐ hypoglycemia

**GENITO-URINARY**
Patient/Family
☐/☐ PMS
☐/☐ painful periods
☐/☐ irregular periods
☐/☐ menopause
☐/☐ prostate
☐/☐ erection difficulties

**CANCER**
Patient/Family
☐/☐
Year of discovery: ____________
Type of cancer: _______________

**CURRENT ALLERGIES:**_____________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

If you have any of the problems listed, please give the date of your last episode and describe your treatment: ______________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

List your surgical history (year & type):__________________________________________
____________________________________________________________________________
____________________________________________________________________________

Describe any accidents or serious injuries:_________________________________________
____________________________________________________________________________
____________________________________________________________________________