

Family Therapy Clinic of Louisiana LLC

Consent for Assessment/Treatment

I understand that:

- My participation in outpatient therapy at Family Therapy Clinic of LA, LLC is strictly voluntary.
- All information obtained in therapy, including psychological assessment data, is confidential and can only be released with written consent. Exceptions to this legal safeguard are:
 - 1) If I am a danger to myself or others
 - 2) Records are subpoenaed by a court of law
 - 3) The therapist discovers abuse or neglect of any child or an adult who cannot physically or mentally protect themselves
- The data from psychological assessment procedures that are performed may be used for research purposes and in the event of such use, I have been assured that my identity will remain totally anonymous in any research database that is derived from review of patient records at Family Therapy Clinic of LA, LLC.
- Any questions that I have may be answered by my therapist or by contacting **Erich G. Duchmann, Ph.D.** at (225) 292-0155.
- By signing this consent form I acknowledge that I have read the information about voluntary consent for treatment and that all of my questions have been answered.

Signature

Date

Parent/Legal Guardian Signature

Date

Witness Signature

Date

Family Therapy Clinic of Louisiana LLC

Counseling Financial Agreement

(Complete Form if Applicable to Services Being Sought)

Psychological Services

- Initial Visit (60-90 minutes) \$180.00
- Therapy Session (45-50 minutes) \$120.00
- Therapy Session (25 minutes) \$66.00

Clinical Social Work/Licensed Professional Counselor Services

- Initial Visit (60-90 minutes) \$150.00
- Therapy Session (45-50 minutes) \$105.00
- Therapy Session (25 minutes) \$55.00

*Telephone consultations will be charged according to the therapist’s normal hourly rate.

1. If using insurance, we will attempt to verify your insurance benefits prior to the completion of your first visit. However, it is ultimately ***your responsibility to call your insurance company*** before your visit and obtain a pre-authorization. Also note that ***pre-authorization from the insurance company does not represent a guarantee of payment.***
2. You will be responsible for payment of all charges incurred at the time of service. This will generally be your co-pay if using insurance. However, it may include the full insurance allowable charge if your deductible has not been met, or the full non-discounted charge if your benefits do not cover the service.
3. If you are unable to make full payment of the account balance at the time of service, you should discuss payment options with the office manager and the clinician providing services. Failure to develop a payment agreement may subject your account balance to late payment charges.
4. Should you fail to make payment in a timely manner and your account is sent to collections, you will be responsible for any additional charges incurred due to the collections process.
5. You should always check in with the front receptionist prior to or after each visit to check account status and schedule any future services that may be necessary. *Missed appointments/or appointments cancelled without a 24-hour notice will result in a no exception \$35.00 fee. (Exceptions will be considered ONLY for potentially hazardous travel condition such as inclement weather.)*
6. There is a \$25 charge for all returned checks.

Please sign and date below if you understand and agree to abide by the above financial requirements.

Signature of Responsible Party

Date

Family Therapy Clinic of Louisiana LLC

Testing Financial Agreement

(Complete Form if Applicable to Services Being Sought)

Psychological Evaluations

- Psychological Screening \$270.00
- General Psychological Evaluation \$640.00 base
 - i. \$544 (15% discount for non-insurance)
 - ii. \$100/hr for additional time needed
- ADHD Evaluation \$840.00
 - i. \$714 (15% discount for non-insurance)
- Full Psycho-educational Evaluation \$1340.00
 - i. \$1139 (15% discount for non-insurance)
- Specific Psychological Assessment \$100.00 base
 - i. \$100/hr testing

Special Assessments and Testing

- IQ testing \$340.00
- Achievement Testing \$340.00
- IQ and Achievement Evaluation \$540.00
- Pre-surgical evaluation \$370.00

*Time to complete evaluation and report is a minimum of 2 weeks, but not typically longer than 4 weeks (depending on time required to complete testing procedures).

*For some evaluations, expedited results of less than 2 weeks may be available (15% surcharge, not billable to insurance)

1. Please note that **preauthorization from the insurance company does not guarantee they will actually pay for services.** Also, be aware that the evaluation procedures are not flexible and **you will be responsible for the full cost of any procedures that your insurance company does not agree to preauthorize.**
2. Insurance coverage varies widely between policies and this is especially true for psychological testing procedures. Therefore, we cannot tell you what the exact final cost for you will be. However, you will ultimately be responsible for:
 - a) Any co-payments that are required by your policy
 - b) Any deductible amounts that are required by your policy
 - c) Any services that are considered "excluded" by your policy
 - d) Any services that your insurance company does not agree to preauthorize when your policy requires a preauthorization
 - e) An out-of-pocket testing materials fee of \$20-\$40

3. Due to the difficulty and delay typically involved in verifying insurance policy coverage for testing services, we require prepayment of 50% of the total evaluation cost that will be applied to anticipated co-payments and uncovered services. As insurance verification/payment is received you will be notified about your remaining balance due. To the extent that services are covered you may be entitled to a refund. Refunds will be issued only after insurance has completed all responses and payments for the services.
4. Two copies of the report will be provided. Additional copies will cost \$1.00 per page plus a \$5.00 service fee and any required postage.
5. If you are not using insurance for testing services, payment plans and discounts may be available.
6. Should you fail to make payment in a timely manner and your account is sent to collections, you will be responsible for any additional charges incurred due to the collections process.
7. You should always check in with the front receptionist prior to or after each visit to check account status and schedule any future services that may be necessary. ***Missed appointments/or appointments cancelled without a 24-hour notice will result in a no exception \$35.00 fee. (Exceptions will be considered ONLY for potentially hazardous travel condition such as inclement weather.)***
8. There is a \$25 charge for all returned checks.

Please sign and date below if you understand and agree to abide by the above financial requirements.

Signature of Responsible Party

Date

Family Therapy Clinic of Louisiana LLC

Consent to the Use and Disclosure of Health Information for Treatment, Payment, and Healthcare Operations

I understand that as part of my healthcare, **Family Therapy Clinic of Louisiana, LLC**, originates and maintains mental health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment.

I understand that this information serves as:

- a basis for planning my care and treatments
 - a means of communication among the many health professionals who contribute to my care
 - a source of information for applying my diagnosis and treatment information to my bill
 - a means by which a third-party can verify that services billed were actually provided
 - And a tool for routine mental health care operations such as assessing quality and reviewing the competence of mental health care professionals.
- ✓ I understand that I have the option of receiving a copy of the **Privacy Notification** that provides a more complete description of information uses and disclosures.
 - ✓ I understand that I have the right to review the notice prior to signing this consent.
 - ✓ I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided, if I request.
 - ✓ I understand that I have the right to request restrictions as to how my mental health information may be used or disclosed to carry out treatment, payment or health care operations and **Family Therapy Clinic of Louisiana, LLC** is not required to agree to the restrictions requested.
 - ✓ I understand that I may revoke this consent in writing, except to the extent that **Family Therapy Clinic of Louisiana, LLC** has already taken action in reliance thereon.

I consent to allow **Family Therapy Clinic of Louisiana, LLC** to use or disclose my protected health information for treatment, payment, and health care operations as indicated below:

No restrictions

I request the following restriction to the use or disclosure of my health information:

Signature of patient or legal representative

Witness signature

Date

August 15, 2010
Notice Effective Date or Version #

This area for use by Family Therapy Clinic of Louisiana, LLC personnel only.

Unable to obtain consent because: _____

Staff Signature

Date