# Springfield Psychological

***Pennsylvania 610-544-2110***
***New Jersey 609-594-4900***
***Delaware 302-268-6105***

## Patient Agreement and Consent Form

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

Thank you for choosing Springfield Psychological (SP)! The contents of treatment, in-office or via telehealth, are confidential with the following exceptions: a) your authorized disclosure to another party; b) if you are a danger to yourself or others; c) a judge's order to disclose information; or d) mandated child abuse reporting. As mandated reporters, we are required to report if a minor is or has been abused, even if we do not see the minor in a professional capacity. We are also mandated to report disclosure by a patient admitting to abusing a minor, even if that minor is no longer in danger. By signing this form, you consent to have your therapist consult with SP clinical staff if the clinical need arises and you also acknowledge that SP support staff has access to all files. If you are referred to another professional within this practice, the clinical staff will consult regarding your case.

**Safety:** Springfield Psychological is committed to providing a safe therapeutic space for our staff and clients. Carrying firearms or weapons and acts of intimidation or violence are not permitted and anyone engaging in these behaviors will be referred outside of the organization

With your written consent, we will share treatment information with other healthcare providers who are also treating you. We do NOT provide any information regarding your treatment to non-healthcare professionals who seek your treatment information for non-treatment purposes. For example, we will not release information for the purpose of any legal proceeding, child custody determination, disability, etc without a court order. *Although we do not involve ourselves in legal proceedings, if court ordered we will do so as an expert witness and bill you directly for such services.*

**Outcomes Measures:** All patients in our outpatient practice are required to complete the outcome measure referred to as Treatment Outcome Package (TOP). A link to complete this measure will be sent to you by email from *Wellness Check,* at admission and every 28 days thereafter. This measure provides Springfield Psychological with a data-driven way to match you with the most appropriate clinician and it also provides you and your clinician with a data-driven way to measure your progress over time. You and your clinician will review the results of your TOP in the treatment session following it's completion, so please make sure to complete the assessment when you receive the link. This link is secure and your information is protected under HIPAA regulations. Once reviewed by your therapist, the data will become part of your record.

As a patient in our outpatient practice, you are expected to manage your day-to-day functioning. However, in the case of an emergency in which you fear you may harm yourself or another, call our emergency coverage at 610-544-2110, ext. 0. If it is after hours, follow the directions for emergency calls.

SP requires a Credit Card on File (CCOF) to receive any services from our providers. Our CCOF Policy allows SP to easily process payments at the time of service (in-person or telehealth) for which you are responsible, as well as service fees related to late cancellations/missed appointments (Therapy Appointments $60 and Psychiatric Appointments $200, in-person or telehealth) and emergency medication refills ($30).

If you are going to miss an appointment, in-person or via telehealth, you must provide 48 hrs notice to avoid receiving a late charge.

**Assignment and Release**: I, the undersigned, agree to assign directly to SP all insurance benefits, in-office or telehealth, otherwise payable to me or insurance policy holder for services rendered. I understand that I am financially responsible for all charges (in-office or telehealth) whether or not paid by insurance. I understand that if I don't pay at the time of service, my CCOF will be billed for my portion of the fee. I hereby authorize SP to release all information necessary to secure the payment of benefits, including relevant clinical information pertaining to in-office or telehealth services provided, which may include the following: diagnosis, treatment plans, summaries of treatment, and/or copies of the clinical chart. I authorize the use of my signature on all my insurance submissions. If I am not the insurance policy holder, I agree to allow SP to release whatever billing information is necessary for payment to be made to SP.

**(OVER)**

**Patient Agreement & Consent Form (Page 2)**

While you are active with our practice, we will send to your Primary Care Physician (PCP) noted below, a summary of your treatment including diagnosis, medication (if prescribed here) and goals, unless otherwise noted by you.

Primary Care Provider Name: _____ ☐ Do NOT release information to my PCP

**Electronic Communication**: Should you choose to communicate with your treating SP professional or our administrative support staff via text or email, please understand that such communications are not HIPAA compliant. If you choose to communicate with us via these methods, please limit the communication to scheduling and do not share treatment-related information.

☐ *I **OPT OUT** from receiving appointment and billing communications from SP via Phone and Email.*
☐ ***I give permission** for SP staff to leave a voicemail message at the following phone number: _____.*

**Telehealth Services** use HIPAA compliant telecommunications technologies such as video conferencing. While telehealth services allow for greater convenience in service delivery, there are risks in transmitting information over the internet that include, but are not limited to: breaches of confidentiality, theft of personal information, and disruption of service due to technical difficulties which may not be in the control of the mental health services provider or the client. Telehealth services are **NOT** to be recorded in any way.

☐ *If over age 14, please indicate with whom we can discuss information concerning the scheduling of your SP appointment(s)*: _____.

I certify that I have read, understand, and agree to all of the information outlined above as well as the Policies and Practices to Protect the Privacy of my Health Information and the Member's Rights and Responsibilities Statement (copies available upon request).

_____ _____
*Patient Signature (age 14 and above)* Date

_____ _____
*Parent /Guardian signature if patient is under 18* Date