Insight Psychological Services, PLLC

5212 E. 69th Place   Tulsa, OK 74136

Informed Consent and Business Policies

Client Name:____

It has been our experience that psychotherapy and psychological testing are most effective when expectations regarding office policies are understood by all parties in advance. Please review our policies and procedures, and then **initial each section** to indicate that you understand and agree with each policy. Insight Psychological Services will be referred to as IPS for the remainder of this document.

______**(initial)** **Confidentiality**

- I am aware that state law and professional ethics require clinicians to maintain confidentiality. No information may be shared without my explicit permission, expect for the following situations:
  - Suspected past or present abuse/neglect of children, adults, and elders will be reported to the authorities (DHS, law enforcement), based on information provided by the client or collateral sources.
  - If the clinician has reason to believe the client is in serious danger of harming himself/herself or has threatened to harm another person.
- I have read the **HIPAA NOTICE OF PRIVACY PRACTICES** and understand the policies, rights and responsibilities outlined in the document. I have been offered a copy of this form for my own records.

________**(initial)** **Professional Fees**

- I am aware of the following fees:
  - Diagnostic interviews (or intakes) are typically 60-75 minutes in length and are $200.
  - Individual therapy sessions are also 50-60 minutes in length and are $180.
  - Psychological testing, report writing, phone consultations, letter writing, meetings with teachers, etc. are $180 per hour.

________**(initial)** **Payments and Insurance**

- IPS will file claims with my insurance company. IPS will provide documentation to my insurance company for claims processing. If the insurance company requires additional information, IPS will provide them with whatever is necessary to process the claim and to maximize my insurance benefits.
- It is my responsibility to familiarize myself with the reimbursement rate, limitations and specific provisions of my health policy, and to obtain any necessary prior authorization
- I am aware that most insurance companies require my clinician to provide them with a clinical diagnosis. In addition, I understand that insurance companies occasionally required additional information, such as treatment plans, summaries, or copies of my entire record.
- I am aware that I am financially responsible for the entirety of psychological services provided in the event that my insurance company does not pay for services rendered. Therefore, it is important that I determine exactly what mental health services my insurance policy covers.
- Co-pays and co-insurance are due at the time of service. **If my child attends an appointment alone or if someone else provides my child with transportation to an appointment, the payment is due at that time.** I may leave your credit card information on file with IPS to use as payment.
- It is my responsibility to notify IPS before my next scheduled appointment if I change insurance plans or providers.
- I am aware that I may terminate treatment at any time without consequence but that I will still be responsible for payment of the services I have received.
- I am aware that if I have not paid for services received, my treatment may be discontinued.

_______(initial) **Court Testimony and Custody Evaluations**

- I am aware that IPS clinicians makes every effort to maintain client confidentiality, and therefore do not testify in court regarding custody, divorce action, or other legal matters.
- I agree not to contact an IPS clinician personally or via my attorney to testify in court.
- If an IPS clinician is contacted or subpoenaed on my behalf for testimony, I agree to pay all IPS court costs and legal fees. Because of the difficulty of legal involvement, IPS charges $5,000 per partial or half day out of the office to attend legal proceedings and $350 per hour to prepare for legal proceedings.

________(initial) **Cancellations and Missed Appointments**

- I am aware that "no showing" for two appointments over the course of 60 days may cause me to be removed from a recurring appointment and be placed on a cancellation list.
- **I understand that it is the policy of this office to charge $100 for missed appointments or cancellations within 24 hours of my appointment.** I must call and cancel 24 hours prior to my appointment.

________(initial) **Contacting IPS**

- I understand that my clinician is often not immediately available by telephone. I know that telephone calls are typically answered by voicemail during business hours. I am aware that most calls are returned within 24-48 hours, with the exception of weekends and holidays.
- I understand that IPS does not provide emergency services and that I should call 911 in the event of a mental health emergency.
- I have read the **ELETRONIC COMMUNICATION POLICY** and understand this document. I have been offered a copy of this document for my records.

________(initial) **Use of Technology**

- I agree to allow IPS to use email, fax, telephone, and electronic records as a means to provide care.

________(initial) **Risks of Psychotherapy/Evaluations and Consent for Treatment**

- I am aware that the practice of psychotherapy and evaluations are not an exact science, and that predictions of the effects of psychotherapy/evaluations are not precise or guaranteed. In order for therapy to be most successful, I understand I will have to work on things we discuss during therapy and at home.
- I understand that psychotherapy/evaluations can have benefits and risks. Psychotherapy/Testing has been shown to have benefits for people that go through it; however, I may experience uncomfortable feelings through the discussion of difficult aspects of my life, completion of psychological testing, and discussion of results of testing.
- I acknowledge that no guarantees have been made to me regarding the results of treatment or procedures provided by the clinician identified below.
- I certify that I have legal standing to authorize participation in evaluation and/or treatment for myself and/or my child.
- I do _______do not _______have questions about this Consent for Treatment/Business Policy.

My signature below indicates that I have read, that I understand, and that I agree to the business policies outlined above.

Client's Name:____ Date of Birth:_________________

Responsible Party:____

Signature of Responsible Party:____

Updated May 24, 2023