Mark Groblewski, LCSW
1110 Nasa Parkway, Ste. 545K
Houston, TX 77058
(832) 687-7915; Groblewski7@msn.com

Informed Consent – (Adult) for Individual, Couples, Family, or Group Therapy

Consent for Treatment
I give full consent for myself to participate in Psychotherapy for Individual, Couple, Family, or Group Treatment. I certify that I have the legal right to seek therapy for myself and am not bringing myself in for the purpose of obtaining testimony from anyone to be used in a lawsuit.

Confidentiality
Information obtained in the process of psychotherapy will not be disclosed to any outside person(s) or agency without my/our written permission except when in the judgment of the therapist such disclosure is necessary to protect you or someone else from harm, or is otherwise legally required and/or allowed by law.

Financial Policy
I am concerned about your mental health expenses and want to address issues pertaining to the cost of services in this office. Much care has been given to the rates set for your therapy. I want to assure you that all charges are in accordance with the customary psychotherapy charges in the area, and they will appropriately reflect the depth of care given and the ability and proficiency required for your care. Feel free to discuss the rate structure with me.

Payment Policy
Payment is to be made at the time of each visit. We will coordinate payment with your insurance company, but this option must be discussed prior to your appointment. Please schedule a time to meet or talk with me. Otherwise, all charges are payable at the time the service is rendered. A fully documented, universally accepted insurance form will be provided as your receipt. Your bill may be paid in cash or by check.

Insurance
Insurance is a personal contract between you and your insurance carrier. My fees are set independently and are a contract between you and my office. We will submit claims for managed care members and your deductible or co-payment is required when service is rendered. If for any reason your insurance carrier does not pay within a reasonable period of time (within 60 days of filing for benefits), you are fully responsible for all charges incurred.

Insurance and Assignment of Benefits
Upon agreement, insurance claims may be filed by Mark Groblewski, LCSW. If agreed upon, I understand that my authorization to assign benefits to Mark Groblewski, LCSW, does not constitute a relief of my financial responsibility for services rendered. I authorize assignment knowing that this does not guarantee that benefits will be paid directly to the provider, and this does not remove my financial responsibility for services rendered. I understand that payment is due at time of service.

Initial_____

Please note: I will provide your therapy treatment and want your active participation. Please make any recommendations you believe will aid in improving your care. I want and need your input and cooperation.
- Mark Groblewski, LCSW

If, for any reason, my insurance carrier does not pay within a reasonable time (within 60 days of filing for benefits), then I am fully responsible for all charges incurred. My insurance is a contract between myself and my insurance company, and I am responsible for all moneys that the insurance company does not pay. All charges are due and payable within 30 days of the first billing.

Missed Appointment and Cancellations

If you find that you cannot keep an appointment, please cancel the appointment at least 24 hours in advance. The courtesy allows other individuals the chance to be seen. **Appointments that are not canceled at least 24 hours before the scheduled time will be charged a $65 fee**. This charge is NOT reimbursable by insurance carriers and **you are personally responsible for that fee**. You may leave a message at 832-687-7915, if necessary; however, the message must be made within the 24 hour-notice period. A cancellation with less than 24 hour-notice will be charged the cancellation fee which is equivalent to the missed appointment fee**. My policy is to secure you credit card number at the initial session, which will be kept on file to bill for cancellations.**

Professional Fees

My 50-minute fee for Individual Therapy is $125.00 after an initial visit fee of $160.00. My hourly fee for Family Counseling and Couple Therapy is $130.00. My 90-minute fee for Group Therapy is $65.00 per member. In addition to weekly appointments, it is also my practice to charge $65 on a prorated basis for other professional services that you may require. This includes but is not limited to, report writing, attendance at meetings or consultations with other professionals whom you have authorized, preparations of records or treatment summaries, or the time required to perform other similar service which you may request of me. Telephone conversations which last more than 15 minutes will be charged at the appropriate prorated therapy session fee.

In unusual circumstances, you may become involved in a litigation that may require my participation. You will be expected to pay for my required professional time, even if I am compelled to testify by another party. Because of the complexity and difficulty of legal involvement, I charge $300.00 per hour – with a 4-hour minimum. This is not a payment for testimony, but to reimburse me for time away from this practice, as well as the preparation and attendance required, at any legal proceeding.

Other Fees:

Please note that the office policy is a $35 fee on all returned checks. Any account which is 30 days past due will accrue interest at the rate of 1.5% per month. A collection agency may take over in case of delinquent accounts. If your account is placed with a collection agency, you will be responsible for all costs associated with the collection of the past due amount.

1. I authorize payments of medical benefits to Mark Groblewski, LCSW, for services rendered.
2. I have read and understand my financial responsibilities under these policies.
3. I hereby authorize the release of any and all medical information necessary to process this claim, to my insurance company and/or managed care company.
4. I have read, understood, agree, and consent to the above-stated conditions necessary to receive psychotherapy services from Mark Groblewski, LCSW.

_____ _____

Patient Signature* Date Witness Date

***Please sign in the presence of Mark Groblewski, LCSW**

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- Mark Groblewski, LCSW

PRIVACY PRACTICES ACKNOWLEDGEMENT

(Please check the box that applies)

☐ I have been presented with the Notice of Privacy Practices in a language I understand and have been given an opportunity to have a copy supplied to me. I have chosen note to take a copy.

☐ I have been presented with the Notice of Privacy Practices in a language I understand and am taking a copy supplied to me.

NAME (Print) _____**Birthdate**_____

SIGNATURE_____ **DATE**_____

YOUR PREFERENCES FOR COMMUNICATION OF PERSONAL HEATLH INFORMATION

In general, the HIPAA privacy rule gives individual the right to request a restriction on uses and disclosure of their Personal **H**ealth **I**nformation **("PHI"). The individual is also provided the right to request confidential communications of PHI be made by alternative means such as sending correspondence to the individual's office instead of their home.**

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (CHECK ALL THAT APPLY).

☐ **Home Telephone at _____**

- ☐ Okay to leave message with detailed information
- ☐ Leave message with name and call-back # only

☐ **Written Communication**

- ☐ Okay to mail to my home address
- ☐ Okay to mail to my work/office

☐ **Fax at_____**

☐ **Work Telephone at _____**

- ☐ Okay to leave message with detailed information
- ☐ Leave message with name and call-back # only

☐ **Cell/Mobile phone communications at _____**

☐ **Other**

_____ **Date**_____

Patient Signature

_____

Printed Name

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The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of Personal Health Information to the minimum necessary to accomplish the intended purpose. These provisions do not apply to an authorization requested by the individual. Healthcare entities must keep records of PHI disclosure. Information provided below, if completed properly, serve as an adequate record.

NOTE: Uses and disclosures to Third Parties may be permitted without prior consent in an emergency.

RECORD OF DISCLOSURES OF PROTECTED HEALTH INFORMATION

+

Date	Disclosed to Whom	Purpose?	Who Disclosed?	What Was Disclosed

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