BEHAVIORAL HEALTH CHOICES

Information and Consent for Treatment

We are pleased that you have selected Behavioral Health Choices. This document is designed to ensure that you understand our professional relationship with you.

I. Client Agreement

All the clinicians at Behavioral Health Choices are professionally trained, experienced and licensed by their professional regulatory boards. The model of treatment typically involves weekly psychotherapy, and less frequent medication management visits. Some clients need only a few sessions to achieve their goals, while others may require longer periods of treatment based on complexity and severity of problems.

Although your sessions may be very intense and psychologically intimate, it is important for you to realize that it is a professional relationship rather than a social one. Please do not invite your therapist to social gatherings, offer gifts, or ask them to relate to you in any way other than in the professional context of your counseling sessions. We will keep anything you say to your therapist/psychiatrist confidential with the following exceptions: (1) you direct us to tell someone else, (2) we determine that you are a danger to yourself or others, or (3) we are ordered by a court to disclose information. We are also mandated to report suspected child abuse.

By signing this form, you are consenting to have your therapist discuss your case from time to time with your psychiatrist for collaboration and consultation.

If at any time for any reason you are dissatisfied with our services, please let your therapist know. If you are not able to resolve your concerns with your therapist, please contact Mary Walsh, office manager.

Therapy sessions are approximately 45 minutes in duration, medication management sessions vary in length but are approximately 15 to 20 minutes.

Therapy/treatment can be terminated by both the client or the clinician/psychiatrist under the following circumstances: 1) If either the client or the clinician/psychiatrist believes therapy/treatment is not being helpful to the client; 2) If the client is not complying with those elements of therapy/treatment essential for progress; 3) If the client's behavior or the behavior of someone in a relationship with the client is harmful or potentially harmful to other clients or the clinician/psychiatrist.

II. Legal Issues

If you are in the midst of any type of legal issue such as litigation, a dispute with your employer, separation or divorce, please inform your therapist immediately. Please be aware that in custody cases, we typically need signed permission from both parents, and that medical records are frequently subpoenaed when litigation is involved. Authorizations to release information regarding legal matters must be on Behavioral Health Choices letterhead. Please remember that Behavioral Health Choices has no control of, or responsibility for how information is handled once it is released to third parties. If you are using your insurance, and that insurance provider changes, or your card numbers or co-pay changes, please let us know.

III. Cancellation/Office Hours

In the event that you will not be able to keep an appointment, you must notify us 24 hours in advance for follow up appointments and 48 hours for initial evaluations. If we do not receive such advance notice, you will be responsible for paying a $50.00 cancellation fee for a missed therapy or medication follow up appointment and $170.00 for an initial visit . Our offices are open during regular business hours and we have a linkage agreement with the Horsham Clinic after.

IV. Emergencies

Behavioral Health Choices has formed a linkage agreement with the Horsham Clinic for after hours and emergency care. Patients who experience a clinical emergency after hours should call 800-237-4477, the designated 24/7 Crisis and Referral Center at the Horsham Clinic.
Please note that adolescent and child clients living outside of Montgomery County should contact their designated 24/7 Crisis Center for Children, or contact their nearest emergency room. The Bucks County Mental Health Crisis Center for Children can be reached by calling ACCESS at 877-435-7709.

V. Social Networking

It is the policy of Behavioral Health Choices that employees do not accept requests for friendship, follows or connections from clients or solicit themselves to clients as friends on social networking sites such as Facebook, Twitter, and other similar sites. This applies to non-active and active clients for a minimum of two years after discharge.

VI. Disability Forms

Please be advised that providers at Behavioral Health Choices are not able to fill in paper work for disability claims. You might need to approach your primary care provider to help you with this.

I acknowledge that the initial appointment is a consultation only and does not establish a treatment relationship. If a clinician at Behavioral Health Choices deems that I would not benefit from BHC's outpatient program, he/she will give recommendations as to what treatment would be more appropriate.

My signature below indicates that I grant consent for Behavioral Health Choices to provide psychological services and counseling to myself and/or minor members of my family.

My signature also indicates that I have received information about how I can express any dissatisfaction.

Client/Guardian Signature _____ Date _____

Client/Guardian Signature _____ Date _____

Therapist Signature _____Date _____

VI. Insurance Assignment

I, the undersigned, have insurance coverage with _____ and assign directly to Behavioral Health Choices all medical benefits. If my insurance company does not cover fees for any reason, I agree that I am financially responsible for all charges. I also hereby authorize Behavioral Health Choices to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I understand that all services provided which are not covered by insurance will be billed separately.

Client/Guardian Signature _____-
Date_____

VII. To Parents of Adolescents

I understand the need for confidentiality between my son/daughter and his/her therapist and that confidentiality will be maintained unless the therapist determines that my son/daughter is a danger to self or others.

Parent/Guardian Signature _____-
Date_____