

# ***Resolve To Heal Therapeutic Associates***

## **CLINICAL POLICY STATEMENT**

**Consent to use and/or disclose Protected Health Information for the purpose of treatment, payment, and health care operations.**

Client information is confidential by law. However we are required by law to report known or suspected cases of abuse or neglect of children, elderly, and the handicapped, and if there is a clear and immediate danger and/or harm to a person, including the client.

In order to carry out treatment, payment, and health care operations we need to use and/or disclose certain health information about you, and ask your consent to do so. You may revoke this consent at any time by your therapist in writing. Please refer to the "Notice of Privacy Practices" for a more complete description of the uses and disclosures of your Protected Health Information.

**I hereby consent to the use and disclosure of my Protected Health Information for the purposes of treatment, payment, and healthcare operations.**

\_\_\_\_\_  
**INITIALS**

**I acknowledge that I have been informed of the Notice of Privacy Practices.**

\_\_\_\_\_  
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**I give permission to communicate with me via cell phone (privacy cannot be guaranteed), and to leave messages on my answering machine or voice mail at home, work, or cell phone.**

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**INITIALS**

### **Fees and Payments**

- Our standard fee is \$125 per session. Adjustments may be made with your therapist.
- Health Insurance may be applicable in some cases. If insurance claims are submitted, the client is still responsible for the fee if insurance company denies the request for benefits.
- Returned checks are subject to a \$15 per item fee.

### **Appointments**

- Sessions are 45 to 50 minutes. If you cannot keep your appointment, please notify your therapist to reschedule. In the absence of 24 hour notification you may be charged for a missed appointment. Please discuss this with your therapist. Insurance companies cannot be billed for missed appointments.

### **Informed Consent**

- You and your therapist will discuss the nature of your treatment, any risks of therapy, the benefits of treatment, and possible alternative approaches

### **Personal**

- All clients are encouraged to have an annual physical examination.

**I have read the Clinical Policy Statement and agree to comply with these policies.**

**Date:** \_\_\_\_\_

**Client Name:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**By signing below I acknowledge that I have received a copy of the Notice of Privacy Practices.**

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_