Family Counseling Center of the CSRA, Inc.
Informed Consent for Treatment

FEES

All aplicable fees/co-payments are collected prior to the beginning of the session. Please have payments ready at time of appointment. Phone sessions will be charged after completion of the session. If you have insurance, your insurance card must be provided at time of visit. Sliding scale fees are determined based on the number in the household and gross household income. Acceptable proof of income is two consecutive paystubs, or most recent tax statements. No additional sessions will be scheduled if there is a balance of three sessions remaining on the account. Once remaining balance is paid, sessions may resume.

Initial _____

Cancellations/Rescheduling Appointments/No Shows/Late Appointments

If you need to change or cancel an appointment we require a **24 hour notice**. If you do not cancel or reschedule your appointment within a 24 hour notice, you will be charged your usual and customary fee. If you are going to be late, please contact our office as soon as possible to notify us. If you are late up to twenty minutes, you will be seen for the remainder of your appointed hour. Anything greater than twenty minutes will be rescheduled.

The Family Counseling Center has confidential voicemail available 24 hours 7 days a week.

Any messages left after business hours will be returned or followed up with the next business day.

In the event of an emergency please call 911, go to your local hospital emergency room, contact the Georgia Crisis Line at 1-800-715-4225, National Suicide Prevention Hotline at 1-800-273-8255, or contact the Augusta Domestic Violence Hotline at 706-736-2499..

Initial _____

Client Responsibilities

The Family Counseling Center is a space of safety. We ask that all people on the premises to act in a congenial manner towards one another, and respects the privacy and safety of others. The Family Counseling Center reserves the right to suspend and/or terminate services with clients whose behavior is disruptive, abusive, or dangerous. This also includes showing up to a session under the influence of any substances. No weapons are allowed on the premises of Family Counseling Center. It is your responsibility to update contact, employment, and financial information when changes occur. Please direct these updates to the front staff.

Initial _____

Release of Information

I authorize release of information to health care providers, institutions, and referral sources for the purpose of diagnosis , treatment, consultation and professional communication. As the insured client, I further authorize the release of information for claims, case management, benefit administration and other purposes related to my health plan. I further understand that I can withdraw this concern for release of records/retention at any time.

Initial _____

Confidentiality

The Health Information Portability and Accountability Act (HIPAA) is meant to insure that your records are maintained in a private and secure manner. Family Counseling Center treats these records as confidential property and they are not released without your written authorization. Exceptions, uses and disclosures are explained in the Notice of Privacy Practice Form (NPP). All information between practitioner and patient is held strictly confidential. There are legal exceptions to this as stated in the NPP Form. I have read and been given a copy of the NPP Form and understand that information obtained during treatment may be disclosed based upon these ethical and legal requirements. All written and spoken material from any and all sessions is confidential unless written permission is given to release all or part of the information to a specified person, persons, or agency. If group therapy is utilized as part of the treatment , details of the group discussion are not to be discussed outside of the counseling sessions.

Initial _____

Court Involvement

Family Counseling Center does not participate in any activities involving the court system such as: testifying, depositions, etc.

Initial _____

Consent for Treatment

I hereby consent to treatment as deemed appropriate by the Family Counseling Center.

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Signature of Client Date

General Consent for Child or Dependent Treatment

I hereby consent to treatment of the client, and on the clients behalf legally authorize the therapist to deliver mental health care services to the client.

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Signature of legal Guardian /Legal Representative

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Relationship to Patient Date

Emergency Contact

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Name Phone Number

(Updated December 2015)