

ProActive Behavioral Services

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CONSENT FOR TREATMENT:

The undersigned authorizes Proactive Behavioral Services (hereinafter; PBS) and staff to render to the client(s) all customary mental health care based on a client(s) clinical presentation. The undersigned agrees that PBS will not be responsible for the safety or care of the client if the client leaves the premises/treatment prematurely and will indemnify PBS from any loss or injury which may occur as a result of leaving treatment against medical advice.

USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS:

I, (print name) _____, understand that as part of my health care, Proactive Behavioral Services originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means for communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and treatment information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been offered a copy of the *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent.
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that PBS is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this practice may refuse to treat me and will provide referrals for continued care.

I further understand that PBS reserves the right to change their notice and practices. Prior to implementation, PBS will notify clients of the revised practices and will post changes within the practice for a 90-day period of time and will send notice to the address I have provided.

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and **should I consent** to such disclosure for these permitted uses, disclosures will be released via secure electronic/fax or paper/mail format. Generally, your medical information may only be shared with you, your insurance company and those person's you authorize ProActive Behavioral Services to release information to in writing. Exceptions to this include plans to harm yourself, to harm others, or physical/sexual/emotional/medical neglect or abuse of an elder or minor. If you do not want your medical information shared with your insurance company, your insurance company has the right to not pay for your treatment. If you do not want your information shared with your insurance company, you must inform ProActive Behavioral Service of this prior to your initial treatment in writing.

PAYMENT FOR SERVICES: ProActive Behavioral Services provides the services of billing your insurance carrier for services rendered. Typically, clients have an annual deductible and co-insurance or co-pay for services provided. We will make every attempt to verify your benefits prior to your treatment. By signing this you authorize PBS to bill your insurance for services rendered. The amounts billed to your insurance and you range from \$80.00 to \$2000.00 based on the service provided to you. PBS contracts with insurance companies who often determine an allowable charge based on PBS's contract with them. Therefore, our charged rate and the allowed rate may differ. In the event your insurance company does not cover the services you received, we encourage you to appeal with the insurance. Ultimately the financial responsibility for services rendered is the responsibility of the client(s) and the legal guardian. In the event that your account becomes past due and is turned over to collection, you will be responsible for all cost of collections, including collection agency expenses and fees not to exceed 50%, and all costs associated legally. PBS and the assigned collection agency retain the right to report late and/or non-payments to credit bureaus. PBS and its assigned collection agency also retain the right to contact you at home, your cell phone, and/or your place of employment in order to collect outstanding monies.

NON-COMPLIANCE WITH TREATMENT:

If you choose to cancel or not show for an appointment the physician/psychologist/therapist will determine the urgency of contacting the client based upon the clinical significance of the client's condition. If it is determined that your medical condition is of such significance that you need ongoing care we will contact you via telephone and if that fails, certified mail. **In addition, for appointments not cancelled 24 hours prior to the appointment, you will be charged from \$50.00 to \$130.00 based upon the licensure level of your practitioner and your insurance will not cover the missed appointment.**

We will document in your medical record your no-show or canceled appointment. We will counsel you about the impact of missed appointments whether they are cancelled or you simply did not show. We will advise you of the likely outcome if the clinical recommendations are not followed or ignored. We may call you or send a letter if we have not been able to schedule an appointment with you.

If you chose to be non-compliant on an ongoing basis with treatment we will warn you in writing that if therapist/physician recommendations are not followed within a specified period of time, it may be necessary to terminate the patient/practitioner relationship. If substantial compliance is not achieved, to be determined by the treating practitioner(s), the practitioner may consider terminating the professional relationship with you and will provide you with external agencies to continue your care.

SUPERVISION OF PRACTITIONERS:

PBS provides ongoing training opportunities for practitioners who are licensed in the State of Illinois to practice their profession, but are seeking additional training and experiences to acquire additional training and experiences for purposes of additional licensure within The State of Illinois. Part of this process involves clinical supervision of clients receiving services at PBS. The supervision is provided by a clinician within PBS and supervision occurs on an ongoing basis and as needed based on client's needs. Clinicians receiving supervision on their clinical cases will discuss this at the onset of treatment with their clients.

TELE-MEDICINE SERVICES:

In some cases, telemedicine provides behavioral health services via video and audio-conferencing tools that are HIPAA compliant for your privacy. Some providers provide only tele-therapy services and others conduct services in person face to face. You agree to discuss the different services provided at Proactive Behavioral Services. At this time, you agree to consent to telemedicine services by signing this document. Should you choose not to receive tele medicine services, you will provide this choice to our practice in writing. You understand that some providers may not be able to treat you without telemedicine services and we may not have a replacement provider for you.

BREACH OF CONFIDENTIALITY:

In the event it is determined that a client presents as suicidal or homicidal, you may be hospitalized against your will. Licensed medical professionals at a hospital who will evaluate you will ultimately determine if hospitalization is necessary. If you pose a threat to yourself or others while in outpatient treatment, you will be instructed to go to the nearest hospital for an evaluation for possible inpatient admission or the police department may be called to initiate a wellness check on your well-being. Persons who pose a danger to themselves or others can be admitted involuntarily under certificate and petition. In addition, if you are an adult who has been

physically or sexually abusive towards a minor, the Department of Child and Family Services (DCFS) will be notified and you will likely be investigated. These are legal mandates that healthcare providers must follow and are non-negotiable. In addition, documentation related to marital and/or couples therapy is considered Privileged information. This means that documentation from this type of clinical service belongs to both parties and both parties must agree to release such documentation. In the event of marital discord leading to dissolution of marriage or divorce, the clinical work occurring at PBS is for clinical purposes only and are not intended to be used as expert evidence as part of a divorce process. PBS practitioners will not cannot engage in divorce processes or other legal matters as we cannot change our role from treating clinician to expert witness as these are two very different roles and it is unethical for practitioner to have a dual relationship with clients.

LEGAL INVOLVEMENT: In the event your treatment involves you being involved in legal matters including divorce, child custody or criminal, we are your “Treaters” meaning we have no formal legal opinions related to your legal matters. We do not provide formal legal or expert opinions or statements unless you have specifically contracted with us for this purpose and your healthcare provider is deemed experienced enough in the area by his/her profession. There are different payment rates for these types of services and will be provided to a client when requested for a current legal matter. We cannot start your behavioral health treatment as a “Treater” and then change to a legal expert, as this would be unethical and would likely be dismissed by the courts. We will however from time to time provide to you with a letter indicating your involvement with treatment and your compliance with treatment should you ask for this. Again we will not provide any legal opinions and our work with you cannot be used for this purpose without a prior written request and agreement. In the event your practitioner is court ordered to partake in legal matters pertaining to you, we require a \$3,600.00 retainer paid up front at \$450.00 an hour. This fee/time structure starts when the practitioner leaves their home or workplace to participate in legal matters. In such instances, we will likely be informing the presiding judge that we are “treaters” and not court experts. Should time allocation exceed 8 hours of time, additional retainer monies will be paid prior to additional involvement.

MEDICATION REFILLS: When prescribed medications by a prescribing doctor, you are required to attend your doctor appointments per your doctor’s recommendation based on your clinical symptoms and length of stability with symptoms and medication dosages. In the event you request a medication refill via phone or via a written prescription mailed to you, a charge will be billed directly to you in the amount of \$20.00 and your insurance company will not cover this fee. Attending regular appointments with your prescribing doctor is important to your healthcare to monitor for side effects and make appropriate changes to medications on an as needed basis.

RESPONSIBILITY FOR DESTRUCTION OF PROPERTY:

The undersigned understands that the clients are responsible for any damage to or destruction of the practice physical property, or property belonging to others which may be located within the practice. The undersigned agrees to accept liability for and reimburse the practice or the owners of property, which the client may damage or destroy.

CAMERAS:

For the safety of our clients, patients, staff as well as the safety of vehicles, secure cameras are used in our office waiting room, common hallways, and/or near our entrance and exit. These cameras are confidential and password protected. In accordance with healthcare guidelines, these cameras are video only and are placed openly in our office public areas within our buildings in Algonquin and Inverness.

ACKNOWLEDGE RECEIPT OF CLIENT RIGHTS:

The undersigned acknowledges that a copy of the client rights has been given to them, that these rights have been explained, and that they understand these rights.

I fully understand and accept the terms of this consent.

Patient’s / Client’s Signature (If over 12 years)

Guardian (If client is under 18 years)

Date_____

Date_____