CRUZ CLINIC and INTEGRATIVE PSYCHOLOGY

CONSENT TO SERVICES

Patient Name: ____ Date of Birth: __________________________

(Please initial each point to verify understanding)

___ I understand that my records at Cruz Clinic and Integrative Psychology are confidential. These records can be released only as allowed by law under the statutes of the State of Michigan and Federal guidelines, or as allowed by my signature on a release form, with the exceptions written below and in other patient information I have received.

___ I acknowledge that I have been given the opportunity to review the Notice of Privacy Practices for Cruz Clinic (HIPAA) pertaining to my right to privacy and the confidentiality of my protected health information and that upon my request, a copy will be provided to me. I further understand that at any time I may contact the Cruz Clinic/Integrative Psychology administrator in reference to any concern or question I may have regarding the notice or my rights.

___ I understand that the services I will receive at Cruz Clinic/Integrative Psychology are based on currently accepted practice in the fields of mental health and/or substance abuse treatment. I also understand that the outcome of treatment cannot be guaranteed and that services continue only with my voluntary consent. I have been provided with the name and credentials of the clinician who will provide services to me. I understand that all providers are either fully licensed or under the supervision of a fully licensed professional.

___ If services are paid either in part or in full for by a third-party payor such as an insurance company, I understand that the funding source or its agent has the right to examine my records at any time. I hereby authorize the examination of my patient records sources as required for reimbursement and/or clarification of services. I also understand that it may be necessary to release information regarding me to a Case Manager or insurance verifier from my third-party payor for Cruz Clinic to obtain authorization to provide services. I give permission for this release. I also give my permission for Cruz Clinic/Integrative Psychology to release information acquired to process billing claims for services provided to me by the third-party payor reimbursing for these services.

___ I understand that fees for services are to be paid at the time of the appointment, unless other arrangements have been made. If my third-party payor does not cover any fees or any portion of fees for the services I have received, I accept responsibility for them. If maximum third-party benefits have been reached, I understand that I am responsible for any fees for services subsequently rendered.

___ Cruz Clinic's pamphlet, "Important Information for Patients" is available on our websites Cruzclinic.com and IntegrativeA2.com. This pamphlet describes the policies and procedures of Cruz Clinic/Integrative Psychology regarding confidentiality of patient records, emergencies, fee payment requirements, canceled and missed appointments, termination and discharge from treatment, and my rights and responsibilities as a recipient of services.

___ I understand that it is my responsibility to know my insurance policy benefits. I realize that Cruz Clinic/Integrative Psychology has contacted my insurance company to receive my benefit information, yet sometimes the insurance companies do not give clinics accurate information. Payment is subject to the terms of your insurance policy and can only be determined at the time the claims are processed. Therefore, I realize it may be in my best interest to contact my insurance company myself to verify this information. If Cruz Clinic/Integrative Psychology was quoted with incorrect information, resulting in lesser benefit coverage, I understand that I am responsible for the difference. Many clients have found it helpful to ask the following questions to my carrier:

Is out-patient mental health a covered benefit?
If covered, are there a certain number of visits allotted and or any parameters regarding the duration of therapy allowed?
Will therapy charges be applied to my deductible?
Are there any co-pays that I will be responsible for? Do I need pre-authorization?

___ **I understand that I will be charged $75 for missed appointments and late cancellations with less than 24 hours' notice. For psychological assessments (such as ADHD evaluations and other formal psychological evaluations) I will be charged a $100 late cancellation fee if I cancel with less than 72 hours' notice of my scheduled appointment**. I am aware that because third-party payors, such as insurance companies, will not pay for missed appointments or late cancellations, any appointment that is missed or canceled without my giving 24 hours' notice will be billed

(Please continue on reverse side)

directly to me. I understand that I may be billed for these appointments at Cruz Clinic/Integrative Psychology's usual and customary fee. Payment for a missed or late canceled appointment is due within two weeks of the appointment. If treatment or diagnostic evaluation is terminated by my choice or because of violation of program rules, I agree to pay all outstanding fees existing at the time of termination. Cruz Clinic/Integrative Psychology utilizes an automated system which offers reminder calls/texts/emails two days prior to your appointment. I understand that this automated reminder is strictly courtesy, and I further understand that I am still responsible for a No Show/Late Cancel fee if I do not receive this reminder.

___ I agree to inform Cruz Clinic/Integrative Psychology of any changes in my health insurance benefits and to assign insurance benefits to Cruz Clinic/Integrative Psychology. I understand and hereby agree that accounts more than 90 days delinquent, excluding those where payment is made directly to Cruz Clinic by a third payor (e.g., an insurance company), may be subject to collection action.

___ If I have been referred to Cruz Clinic/Integrative Psychology by a court, agency, Employee Assistance Program, physician, attorney, hospital, or another mental health or substance abuse treatment practitioner or program, Cruz Clinic/Integrative Psychology may want to acknowledge the referral by another professional. In order for this to occur, my consent is necessary. I hereby give consent to this limited release of information. Further, unless specified herein or by statute, the release of any further information to anyone requires my written permission.

___ **I provide Informed Consent to receive telemedicine services.** I understand that telemedicine is the use of electronic information and communication technologies by a healthcare provider used to deliver services to an individual when he/she is located at a different location or site than I am. When possible, a telemedicine visit will be done through a two-way video where the healthcare provider will be able to see my image on the screen and hear my voice and I will be able to see and hear and see the healthcare provider. I understand that the laws that protect privacy and the confidentiality of medical information including (HIPAA) also apply to telemedicine. I will be responsible for any copayments or coinsurances that apply to my telemedicine visit. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment. I understand that due to HIPAA privacy policies, I may not record my session in any manner. If a session is recorded without prior agreement with the provider, all services at Cruz Clinic will be immediately terminated.

My signature below acknowledges that I am voluntarily authorizing diagnostic and treatment services at Cruz Clinic/Integrative Psychology for myself. I recognize that I may refuse any aspect of treatment. I also accept that such a refusal may result in termination of services by Cruz Clinic/Integrative Psychology. If termination of services does occur, I understand that I have the right of appeal. Further, I have read, understand and accept what is written in this "Consent To Services" and the "Important Information for Patients" pamphlet. I understand that I may request a copy of this "Consent To Services" form.

By typing my name below, I understand and agree that this form of electronic signature has the same legal force and effect as a manual signature.

_______________________________________ _______________________________

Signature of Patient/Guardian Date

_______________________________________ _______________________________

Signature of Witness Date

Patient Name ____________________

Date of Birth ______________________