CRUZ CLINIC and
INTEGRATIVE PSYCHOLOGY

CONSENT TO SERVICES

Patient:_____ Date of Birth:_____

(Please initial to verify understanding)
___ I acknowledge that I have received Cruz Clinic's pamphlet, "Important Information for Patients," in which is described 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 my records, or the records of my dependent, at Cruz Clinic 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 (HIPPA) pertaining to my right to privacy and the confidentiality of my protected health information. I understand 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, or my dependent, will receive at Cruz Clinic/Integrative Psychology is 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, or my dependent. I understand that all providers are either fully licensed or under the supervision of a fully licensed professional.

___Also, I understand that in order for Cruz Clinic/Integrative Psychology to provide care to me or my dependent, I may be asked to consult with a psychiatrist when this is considered necessary by a clinical staff member. I too may ask to consult with a psychiatrist on staff at Cruz Clinic/Integrative Psychology, if I consider this necessary. Further, I may request that I be referred to another organization for services.

___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 or my dependent's 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, or my dependent, to a Case Manager or insurance verifier from my third-party payor in order 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, or my dependent 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, or my dependent 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.

___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 was quoted 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 question 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 for missed appointments and late cancellations with less than 24 hours notice. I am aware that because third-party payors, such as insurance companies, will not pay for missed appointments or late

(Please continue on reverse side)

cancellations, any appointment that is missed or canceled without my giving 24 hours notice will be billed 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 makes reminder calls the day prior to your appointment. I understand that this automated call is strictly a courtesy call, and I further understand that I am still responsible for a No Show/Late Cancel fee if I do not receive this call.

___ Yes, I would like to be included in this reminder call service at the following number _____.
___ No, I would prefer not to get a reminder call.

___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., and 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 required my written permission.

___I recognize that if I, or my dependent, have been ordered by a court to seek services at Cruz Clinic/Integrative Psychology the court will require one or more reports. My separate, written consent is required for this to occur. I understand that Cruz Clinic/Integrative Psychology shall not be obligated to send or release a copy or original of any report or any clinical records concerning me or my dependent to anyone until the balance on my or my dependent's account is paid in full.

___I understand and accept that it may be necessary for Cruz Clinic/Integrative Psychology to reach me by mail or by telephone during, or after, my or my dependent's treatment with Cruz Clinic for confirming or scheduling appointments, billing and payment issues, completing forms, conducting surveys and any necessary follow-up.

My signature below acknowledges that I am voluntarily authorizing diagnostic and treatment services at Cruz Clinic/Integrative Psychology for myself, or my dependent. 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 also understand that I may request a copy of this "Consent To Services" form.

_____		_____
Signature of Patient	Date	Witness
_____		_____
Signature of Parent/Guardian	Date	Witness

Patient Name _____
Patient I.D. _____