Informed Consent – Minor

I, ________________________ ***(Parent/Legal Guardian)***, hereby attest that I have voluntarily given my consent for the given minor or the person under my legal guardianship at New Hope Counseling, hereby referred to as the "Agency". Further, I consent to have treatment provided by a licensed Mental Health Counselor or a Master's level Resident or Intern in collaboration with his/her approved licensed supervisor. The rights, risks and benefits associated with the treatment have been explained to me. I understand that counseling may be discontinued at any time by either party. The Agency encourages that this decision be discussed with the treating counselor. This will help facilitate a more appropriate plan for discharge.

Fees and Payment Information

1. Clients are expected to pay the counselor directly at the time of service by cash, check, credit/debit card (Visa, Master Card, & Discover), or Health Savings card. If paying by check, please make check payable to Redeemer Presbyterian.
2. There is a $20 fee for all nonsufficient funds incurred via returned checks or bank/debit card payments.
3. New Hope is not responsible for any HSA insurance card that does not approve your treatment.
4. When appointment fees are not paid in timely manner, a collection agency may be given appropriate billing and financial information about you, but will not receive any clinical information.
5. If your insurance company doesn't provide financial reimbursement for your treatment or is cancelled at any time during treatment, you will be responsible for all of the outstanding balance.
6. Insurance companies do not provide financial reimbursement for "no shows" or "late cancellations". In such cases, payment for the missed appointment becomes the responsibility of the client. PLEASE INITIAL ________

Third-Party Payer Rights

1. In order for New Hope Counseling to contact your insurance company on behalf of your counselor, this consent must be signed by you to enable New Hope Counseling pre-authorization to request eligibility and benefit information and to file any insurance claim or process necessary paperwork. Client data of clinical outcomes may be used for program evaluation or with your insurance company, but Protected Health Information (PHI) as stipulated by the Department of Health and Human Services will not be disclosed to any outside sources without your written consent.
2. I authorize New Hope Counseling to disclose client records to any listed third-party payer for the purpose of receiving payment reimbursement. This includes: health insurance carriers, Employee Assistance Program (EAP) providers, and Church Assistance Program (CAP) coordinators with affiliated churches. The Agency is not responsible for any client disclosure (i.e. diagnostic information, date of service, billing information, etc.) from a health insurance carrier to the primary insured. PLEASE INITIAL _________

Emergencies

New Hope Counseling offers outpatient mental health counseling services only. In addition, New Hope Counseling does NOT have a 24 hour answering service. In the case of a crisis, if you or your loved one requires immediate care, please call 911 or go to your nearest emergency room. PLEASE INITIAL ________

Client Rights

1. To have the counselor available at the appointment time agreed upon in advance.
2. To understand any issue related to treatment or the counseling process.
3. To ask questions about your counselor, his or her methods, and/or the direction the counseling is headed.
4. To discontinue counseling at any time. Should you decide to discontinue, your counselor may request a termination session to discuss progress or areas of continuing concern. PLEASE INITIAL ________

Client Responsibilities

1. To arrive for counseling sessions on time, so that the full time set aside can be utilized maximally.
2. To bring your contracted payment for counseling sessions in the form of cash, check, credit/debit card, or Health Savings card to your counseling appointment.
3. **To cancel appointments 24 hours in advance**, so that the counselor can plan an alternative use of his or her time. Failure to notify the counselor within this time frame will result in your being charged for the full cost of that session. However, exceptions to this can be made in cases where emergencies, illness, and/or other unforeseeable events arise. Please note: If frequent cancellations occur (even for emergencies, illness, etc.), the counselor will discuss this with you and you may be required to pay for subsequent sessions in advance or consider the possibility of terminating or pausing counseling.
4. Cooperate with your counselor in treatment planning and process. Counselors do not possess the ability to change your life or fix your problems. Resolution will only come through consistent effort on your part.
5. Please do not offer the counseling staff/ interns any type of gift. Due to ethical considerations, they will not be able to accept them. PLEASE INITIAL __________

Limits of Confidentiality

The client record and all subsequent protected health information maintained by the Agency is protected by Federal and/or State laws and regulations. Generally, the Agency may not say to a person outside the Agency that you attended treatment or disclose any information identifying you as an alcohol or drug abuser unless:

A) You consent in writing and/or,
B) The disclosure is allowed by a court order and/or,
C) The disclosure is made to medical personnel in a medical emergency, or to qualified personnel for research, audit, or program evaluation.

Violation of Federal and/or State laws and regulations by a treatment facility or practitioner is a crime. Suspected violations may be reported to appropriate authorities. Federal and/or State laws and regulations do not protect any information about a crime committed by you either at the Agency, against any person who works for the program, or about any threat to commit such a crime. Federal laws and regulations do not protect any information about suspected child, vulnerable adult abuse, or neglect from being reported under Federal and/or State laws to appropriate State or Local authorities.

Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful. It is the Agency's duty to warn any potential victim, when a significant threat of harm has been made. In the event of your death, your spouse or an authorized minor's parent/legal guardian have a right to access your records. PLEASE INITIAL ____

Agreement with New Hope Counseling / Waiver of Liability

I understand and acknowledge that Redeemer Presbyterian Church, the staff, interns, residents, and/or volunteers would not allow me to participate in these services without releasing and holding harmless Redeemer Presbyterian Church, the Central Indiana Presbytery, and the Presbyterian Church in America. PLEASE INITIAL _________

Consent to Receive Services and Referral Source Contact

By signing below, I consent to participate in counseling services offered by New Hope Counseling. I understand I am consenting and agreeing only to those services that New Hope Counseling associates are qualified to provide within their scope of license, certification, and training as, or under the supervision of, a licensed professional. PLEASE INITIAL ________

Printed Name of Minor: ______________________ Printed Name of Parent/Legal Guardian: __________________________

Signature of Parent/Legal Guardian: ____________________________ Date: ________