#### **INFORMED CONSENT and OFFICE POLICIES**

Thank you for choosing KLC Support Services, LLC. I realize that starting counseling is a major decision and you may have many questions. This document is intended to inform you of KLC Support Services, LLC policies, State and Federal Laws and your rights. Kim Censurato, LPCMH has earned a Bachelor of Art Degree in Psychology from Rutgers University and a Master of Arts Degree in Counseling from The College of New Jersey. She is licensed by the States of Delaware and Pennsylvania as a Licensed Professional Counselor of Mental Health.

Please read each section carefully and ask any questions prior to signing.

**CONFIDENTIALITY AND EMERGENCY SITUATIONS**: Your verbal communication and clinical records are strictly confidential except for: a) information (diagnosis and dates of service) shared with your insurance company to process your claims, b) information you and/or you child or children report about (past or present) physical, sexual abuse or elder abuse; then, as a mandated reporter, I am legally obligated to report this to the Division of Family Services, c) where you sign a release of information to have specific information shared and d) if you provide information that informs me that you are in danger of harming yourself or others e) information necessary for case supervision or consultation and f) or when required by law. If a situation for which the client or their guardian feels urgent attention is necessary, please call the office at 302-287-5519. If no return call is received within 15 minutes, the situation escalates or there is an immediate emergency, the client or guardian understands to contact the emergency services in the community (911) or go to the nearest Emergency Room. E-mail and text messages are not acceptable forms of communication in urgent or emergent situations as they may not be received and are not confidential. By signing below, it acknowledges that you have read and agree to this policy and have received a copy of the procedures for urgent and emergency situations.

***Signature(s)* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­**

**THIRD PARTY CONSENT:** I grant permission for correspondence to be exchanged with the identified insurance Company for billing and treatment purposes. I agree that the information provided is true and correct. Regardless of Insurance coverage I will be responsible for the payment of provided services and any professional services rendered.

**Print Name*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* Date: *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

**CANCELLATION POLICY:** Lastly, if you need to cancel or reschedule an appointment, please give 24 business hours advance notice, otherwise you may be billed $50.00. By signing below, it acknowledges that you have read and agree to this policy, and have received a copy of the full cancelation policy.

## Signature(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­

**FINANCIAL/INSURANCE ISSUES:** As a courtesy, we will verify your insurance prior to initial session and bill any in-network insurance company. We ask that at each session you pay your co-pay. In the event you have not met your deductible, the full fee is due at each session until the deductible is satisfied. If your insurance company denies payment for any reason, you are responsible for the balance due. In the event we are not a participating provider, we ask you to pay the full fee at the time of services and we will provide you with necessary documentation (Super Bill) to submit on your own for reimbursement as per your coverage. If your balance exceeds $300.00 we will need to ask that you pay for services when rendered. By signing below, it acknowledges that you have read and agree to this policy and have received a copy of the fee schedule.

## Signature(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­

**CONSENT FOR TREATMENT OF ADULT (SELF):**

I hereby authorize treatment for myself, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. I fully understand that treatment will remain confidential unless there is a risk of self-harm or a threat of harm to others, and in accordance to Confidentiality and Emergency Situations portion of this form.

## Signature(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­

**TELEMENTAL HEALTH INFORMED CONSENT**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, (print name) understand that telemedicine is the use of electronic information and communication technologies by a health care provider to deliver services to an individual when he/she is located at a different site than the provider; and hereby consent to [name of provider] providing health care services to me via telemedicine. According to Delaware code 19 DE Reg. 768 (02/01/16):

“ ‘Telemedicine’ means a form of telehealth which is the delivery of clinical health-care services by means of real time 2-way audio, visual, or other telecommunications or electronic communications, including the application of secure video conferencing or store and forward transfer technology to provide or support health-care delivery, which facilitate the assessment, diagnosis, consultation, treatment, education, care management and self-management of a patient's health care by a health-care provider practicing within his or her scope of practice as would be practiced in-person with a patient, and legally allowed to practice in the State, while such patient is at an originating site and the health-care provider is at a distant site.”

I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine. As always, your insurance carrier will have access to your medical records for quality review/audit.

I understand that 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 may revoke my consent orally or in writing at any time by contacting KLC Support Services, LLC at 302-287-5519. As long as this consent is in force (has not been revoked) KLC Support Services, LLC may provide health care services to me via telemedicine without the need for me to sign another consent form.

***Signature(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*Date*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

**NOTICE OF PRIVACY PRACTICES AND CLIENT RIGHTS:** I/We have read and received a copy of the Notice of Privacy

Practices and Client Rights document.

## Signature(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­

**COORDINATION OF TREAMENT:** It is important that all health care providers work together. As such, we would like your permission to communicate with your primary care physician, treating physician and/or psychiatrist. Your consent is valid for one year. **Please understand that you have the right to revoke this authorization, in writing, at any time by sending notice. However, a revocation is not valid to the extent that we have acted in reliance on such authorization**. If you prefer to decline consent no information will be shared.

\_\_\_\_**You may inform my physician(s) \_\_\_\_I decline to inform my physician**

**(Signature required below even if decline)**

**PHYSICIAN, PSYCHIATRIST AND/OR TREATING PROVIDER NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

##### CLINIC/GROUP NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­\_\_\_\_\_\_\_\_\_\_

**ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**FAX: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

## Signature(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CLIENT CONTACT CHOICES:**

*May we contact you at* ***home******YES NO*** *(circle one)? May we leave a voice message?* ***YES NO*** *(circle one)?*

*Home Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*May we contact you at* ***work******YES NO*** *(circle one)? May we leave a message at work?* ***YES NO*** *(circle one)?*

*Work Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*May we contact you by* ***cell phone******YES NO*** *(circle one)? May we leave a message on cell?* ***YES NO*** *(circle one)?*

*Cell Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*May we contact you by* ***email******YES NO*** *(circle one)? Would you like* ***email*** *appointment reminders?* ***YES NO*** *(circle one)?*

*Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*