PHYSICIAN NOTICE AND RELEASE OF INFORMATION

Most insurance plans request that the therapist notify the physician that their patient is being seen in counseling. Please complete and sign. If you do not wish for your physician to have this notice in your medical files, please indicate below.

____
Name of MD

____
Address of MD

____
City, State and zip of MD

Presenting Problem(s):____

Proposed Service Plan:____

The client named below is receiving psychotherapy at this office with Desert View Family Counseling. The client has indicated that you are the primary physician _____ or psychiatrist_____.

The client's insurance has requested that you be notified, and the client has authorized this notice. I look forward to working with you in a team effort for the benefit of the client.

If you wish to contact me, please call (505) 326-7878.

Thank you.

Therapist

I_______________________ authorize _______ (do not authorize _______) that this
Print Your Name

notice be sent to the above named doctor and further authorize consultations between the patient's doctor and therapist relative to my medical and psychological care.

____ Date ___________
Signature of patient or guardian of minor.

CONSENT TO TREAT

1. **Consent to Evaluate/Treat:** I voluntarily consent that I will participate in a mental health evaluation and/or treatment by staff from Desert View Family Counseling. I understand that following the evaluation and/or treatment, complete and accurate information will be provided concerning each of the following areas:
   a. The benefits of the proposed treatment
   b. Alternative treatment modes and services
   c. Probable consequences of not receiving treatment

2. **Clinical Supervision:** Your case may be staffed with the clinical director and/or other licensed therapists within the agency. This is to ensure the best possible outcome for you and your family.

3. **Confidentiality, Harm, and Inquiry:** Information from my evaluation and/or treatment is contained in a confidential medical record at Desert View Family Counseling, and I consent to disclosure for use by Desert View Family Counseling staff for the purpose of continuity of my care. Per New Mexico mental health law, information provided will be kept confidential with the following exceptions: 1) if it is deemed that I present a danger to myself or others; 2) if concerns about possible abuse arise from an intimate partner or household member; or 3) if a court order is issued to obtain records.

4. **Right to Withdraw Consent:** I have the right to withdraw my consent for evaluation and/or treatment at any time by providing a written request to the treating clinician.

5. **Expiration of Consent:** This consent to treat will expire 12 months from the date of signature, unless otherwise specified.

I have read and understand the above, have had an opportunity to ask questions about this information, and I consent to the evaluation and treatment for myself. I understand that I have the right to ask questions to my service provider about the above information at any time.

____________________________________ ________________
Patient Signature Date

____________________________________ ________________
Parent/Guardian Signature (if patient is under 18) Date

____________________________________ ________________
Signature of witness Date

Children and Adolescents

A child fourteen or younger seen in this office must have the signature of a parent. In the case of divorce, the authorization must be signed by both parents or the court document presented giving sole custody

Disclosure Regarding Divorce and Custody Litigation

If you are involved in divorce or custody litigation, our role as therapist is not to make recommendations to the court concerning custody or parenting issues. By signing this Disclosure Statement, you agree not to subpoena us to court for testimony or for disclosure of treatment information in such litigation; and you agree not to request that we write any reports to the court or to your attorney, making recommendations concerning custody. The court can appoint professionals, who have no prior relationship with family members, to conduct an investigation or evaluation and to make recommendations to the court concerning parental responsibilities or parenting time in the best interests of the family's children.

COURT APPEARANCE POLICY

All of Desert Views therapists are licensed, they provides clinical services to parents, families and children. This clinical work takes the form of individual counseling, marital counseling, and services to children. In their clinical role, they cannot assist their clients in divorce or custody litigation, and this is disclosed to each client and client family who come to Desert View Family Counseling for services. As a License Therapists, they cannot disclose any marital therapy, couples counseling or family therapy information without the consent of all their clients.

Please do not ask Desert View to write any reports for the court as we cannot do so. Do not ask them to testify in court, because this will destroy the professional relationship with clients. Desert View Therapists are not custody evaluators and do not do Child and Family Investigation work or Parental Responsibility/Parenting Time evaluations. If the court has appointed a CFI or a PR/PT evaluator, those are the individuals that can make recommendations to the court. They cannot make recommendations to the court concerning parental responsibility or parental time issues. That would exceed their role as a therapist, and would adversely affect their ability to help families, parents and children.

I/we have read and fully understand the forgoing statement and agree to its terms as a condition of counseling services.

Client Signature__________________________________ Date _________________________

Parent/Guardian Signature__________________________ Date __________________________

CLIENT RIGHTS & RESPONSIBILTIES

PLEASE READ AND SIGN THE FOLLOWING PRIOR TO SEEING A DESERT VIEW THERAPIST

CONFIDENTIALITY

Confidentiality means that Desert View Family Counseling has a responsibility to safeguard information obtained during counseling. All identifying information about your assessment and treatment is kept confidential, except as mandated by law. You must sign a release of information before any information about you is given to anyone, except as mandated by law.

In certain situations, mental health professionals are required by law to reveal information obtained during therapy to other persons or agencies without your written consent. In such situations, Desert View Family Counseling is not required to inform you of these actions. Please note the following exceptions to confidentiality:

- Confidentiality does not apply to cases of suspected abuse/neglect of children or the elderly.
- Confidentiality does not apply to cases of potential harm to self or others.
- A mental health professional may disclose confidential information in proceedings brought by a client against a professional.
- Confidentiality does not apply to cases involving criminal proceedings, except communications by a person voluntarily involved in a substance abuse program.
- Confidentiality may not apply in cases involving legal proceedings affecting the parent-child relationship.
- Confidentiality may not apply to cases involving a minor child. In such cases, the mental health professional may advise a parent, managing conservator or guardian of a minor, with or without a minor's consent, of the treatment needed by or given to the minor.

Insurance and managed care companies require personal identification information, diagnosis, symptoms, treatment goals, prognosis, evaluation of progress, and other information before reimbursement is considered. Such companies may also maintain the right to have a copy of your records.

WRITTEN ACKNOWLEDGEMENT AND CONSENT TO COUNSELING

I have read and accept this agreement and herewith consent to counseling/psychotherapy treatment with Desert View Family Counseling.

____ ________________

Client Signature or Parent/Guardian (if under 18) Date

<u>Counseling Fee Financial Agreement</u>

The following is a fee agreement. Please read carefully before signing and ask for clarification on any portion that you do not understand. Please initial after each statement indicating that you understand and agree to the statement:

1. **I agree to pay all fees** at the time of service.: ______ (initial)

2. **Cancellation and no show policy (only initial the one that applies to your situation)**:

   a. (**<u>Commercial Insurance and Self Pay Clients</u>**): There will be no charge if appointments are cancelled 24 hours in advance. Cancellations made on the same day of appointment are subject to late cancellation fee. A $35 fee will be applied to each no show or late cancellations and must be paid prior to scheduling the next appointment. After two no shows/late cancellation clients may be discharged. ________ (initial)

   b. (**Medicaid Clients**): After two no show / no calls or late cancellations, you will be discharged with the option of being referred to another counseling agency of your choice. _______ (initial)

3. I understand that while Desert View Family Counseling does send out reminder calls and/or texts as a courtesy. I am responsible for keeping appointments that have been made, regardless of whether I receive a reminder or not. ____________(initial)

4. Desert View does bill **insurance companies** however you are responsible for all co-pays, deductible, agency fees, and any unpaid or denied claims by your insurance company. ________ (initial)

5. If my account is turned over to collections for non-payment, I will be responsible for up to an additional 33% of my original balance. _____________(initial)

6. **Sliding scale:** It is the mission of The Desert View Family Counseling Services to provide our services to all eligible individuals. Please ask about our sliding scale if you are unable to make full payment at this time. If your financial work sheet determines you may be **eligible for assistance, you will still be responsible for all co pays (if applicable) and all agency fees. PROOF of Income** is required for funding assistance _______ (initial)

I have read the above agreement and have fully understood its contents. By signing below, I am fully agreeing to all of the above statements.

Please keep a copy for your records.

Responsible Party Signature: ________________________ **Date**: _____________

Witness: ____ **Date**: _____________

Grievance Policy

A BILL OF CLIENT'S RIGHTS has been provided and signed by you. If you feel your Case Manager or Therapist has violated any of these rights, you have the right to express your grievance, and appropriate action will be taken to remedy the situation.

STEP ONE:

Submit a completed grievance form to the Executive Director, in a sealed envelope, marked CONFIDENTIAL. You may obtain the grievance form and envelope from the Desert View office staff.

STEP TWO:

The Executive Director will conduct an investigation to determine the facts of the case, complete a report within 10 business days of the receipt of the grievance.

STEP THREE:

Within 10 business days of the receipt of the report, the Executive Director will inform the client, in writing, of the decision, and the reason for the decision regarding the reported incident.

I acknowledge that I have received a copy of Desert View's grievance procedure, and that I fully understand the contents of the document.

Client Signature: ______________________________ Date: __________

Parent/Guardian Signature: ______________________________ Date: __________

Witness Signature: ______________________________ Date: __________