Springfield Psychological
Helping you find the right path.

1489 Baltimore Pike, Suite 250
Springfield, PA 19064
T: 610-544-2110
F: 610-604-9510
www.springpsych.com

Patient Agreement and Consent Form

Patient Information: ***PLEASE PRINT***

First Name:_______________________________ **Last Name:**_________________________________

DOB: _________________________ **Gender:**______________ **Marital Status:**____________________

Address:____

Phone Number 1: ______________________________ **Home** **Cell (Phone & Text)** **Work**

Phone Number 2: ______________________________ **Home** **Cell (Phone & Text)** **Work**

Check one**: I authorize appointment and payment communications via:* ☐ ***Phone Number 1 ☐ ***Phone Number 2***

Email Address: ____

I authorize SP to communicate appointment and payment information via above email address. _____ ***Initial***

Parent(s)/Guardian if Patient is under 18 years old: ____

Emergency Contact Name: ____
Emergency Contact Phone Number: ____

Referring Physician Name:____
Primary Care Physician Name:____
Primary Care Physician Practice Name:____
Primary Care Physician Phone Number:____
☐ **Please check box if you do NOT have a Primary Care Physician.**

Thank you for selecting Springfield Psychological (SP). This document is designed to ensure that you understand our professional relationship. If at any time or for any reason you are dissatisfied with our services, please inform your treating professional or our Office Manager so that your concerns can be addressed.

Please read the following carefully and initial/sign where indicated.

All therapists at SP are licensed, professionally trained and experienced. The relationship with your therapist is a professional one. The contents of treatment are confidential with the following exceptions: a) your authorized disclosure to another party; b) if you are a danger to yourself or others; c) a judge's order to disclose information; or d) mandated child abuse reporting. As mandated reporters, we are required to report if a child is or has been abused, even if we do not see the child in a professional capacity. We are also mandated to report disclosure by a patient admitting to abusing a child, even if that child is no longer in danger. By signing this form, you consent to have your therapist consult with SP clinical staff if the clinical need arises and you also acknowledge that SP support staff has access to all files. If you are referred to another professional within this practice, the clinical staff will consult regarding your case.

Our mission is to help you feel better and manage your life more effectively. With your written consent, we will share treatment information with other healthcare providers who are also treating you. **We will NOT provide any information regarding your treatment to non-healthcare professionals who seek your treatment information for non-treatment purposes.** This means, for example, that we will not release information for the purpose of any legal proceeding, child custody determination, disability, etc.

_____ ***Initial***

Although we do not involve ourselves in legal proceedings, if court ordered we will do so as an expert witness and bill you directly for such services.

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Contact with Primary Care Physician (PCP): Our practice emphasizes good communication among treating professionals and especially with your Primary Care Physician (PCP). While you are an active patient with our practice, we would like to send to your Referring Provider and/or you PCP a brief summary about why you are coming to our office, your diagnosis, medication (if prescribed here) and our treatment plan, as well as ongoing updates as indicated. ____***Initial***

Emergencies: As a patient in our outpatient practice group, you are expected to manage your day-to-day functioning. However, in the case of an emergency in which you fear you may harm yourself or another, call our emergency coverage at 610-544-2110, extension 0. If it is after hours, follow the directions for emergency calls. _____***Initial***

Electronic Communication: Should you choose to communicate with your treating professional or our administrative support staff via text or email, please understand that such communications **are not HIPAA compliant** (and therefore not ultimately secure). Therefore, we recommend that if you choose to communicate with your clinician via these methods, please limit the communication to scheduling and do not share treatment-related information. You may discuss this further with your therapist. ____ ***Initial***

Practice Policies: SP requires a **Credit Card on File (CCOF) to receive services from our providers**. Our **CCOF Policy** allows Springfield Psychological to easily process time of service payments, deductibles (if applicable) and co-insurance amounts which may remain as your out of pocket expenses after your insurance company reimburses Springfield Psychological for services provided, as well as other service fees related to late cancellations, missed appointments and emergency medication refills. Our **CCOF Policy**, **Financial Procedures and Payment Policy** and **Appointment Cancellation Policy** are available for your review at your request. By signing below, you acknowledge that you have been made aware of these policies and agree to the information contained in these policies. ____ ***Initial***

Assignment and Release: I, the undersigned, agree to assign directly to SP, all insurance benefits, if any, otherwise payable to me or insurance policy holder for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. **I understand that if I don't pay at the time of service, my CCOF will be billed for my portion of the fee**. I hereby authorize SP to release all information necessary to secure the payment of benefits, including relevant clinical information pertaining to the services provided, which may include any or all of the following: diagnosis, treatment plans, summaries of treatment, or copies of the clinical chart. I authorize the use of my signature on all my insurance submissions. If I am not the insurance policy holder, I agree to allow SP to release whatever billing information is necessary for payment to be made to SP. ____ ***Initial***

If over age 14, please indicate with whom we can discuss information concerning the scheduling of your appointments at SP:

____

I have read and understand the information outlined above as well as the Policies and Practices to Protect the Privacy of your Health and the Member's Rights and Responsibilities Statement (copies may be requested).

______________________________ ______________

Patient Signature (age 14 and above) **Date**

______________________________ ______________

Parent /Guardian signature if patient is under 18 **Date**

Revised: 1/1/2018