Springfield Psychological
1489 Baltimore Pike, Suite 250
Springfield, PA. 19064
(610) 544-2110

Exton
Havertown
King of Prussia
Philadelphia
North Wales
Sinking Spring
Springfield
West Chester

Patient Agreement and Consent Form

Patient Name:_____**Date of Birth:** _____

Thank you for choosing Springfield Psychological (SP)! 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 minor is or has been abused, even if we do not see the minor in a professional capacity. We are also mandated to report disclosure by a patient admitting to abusing a minor, even if that minor 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.

With your written consent, we will share treatment information with other healthcare providers who are also treating you. We do NOT provide any information regarding your treatment to non-healthcare professionals who seek your treatment information for non-treatment purposes. For example, we will not release information for the purpose of any legal proceeding, child custody determination, disability, etc. *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.*

As a patient in our outpatient practice, 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, ext. 0. If it is after hours, follow the directions for emergency calls.

SP requires a Credit Card on File (CCOF) to receive services from our providers. Our CCOF Policy allows SP to easily process payments at the time of service for which you are responsible, as well as service fees related to late cancellations/missed appointments (Therapy Appointments $55 and Psychiatric Appointments $190) and emergency medication refills, $25.

Assignment and Release: I, the undersigned, agree to assign directly to SP all insurance benefits 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 the following: diagnosis, treatment plans, summaries of treatment, and/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.

While you are active with our practice, we will send to your Primary Care Physician (PCP) noted below, a summary of your treatment including diagnosis, medication (if prescribed here) and goals, unless otherwise noted by you. SP is an independent practice and not affiliated with any healthcare system or hospital through an employee/employer agency, joint venture or other relationship.

Primary Care Provider Name:	☐ Do NOT release information to my PCP

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. If you choose to communicate with us via these methods, please limit the communication to scheduling and do not share treatment-related information.

☐ *I **OPT OUT** from receiving appointment and billing communications from SP via Phone and Email.*
☐ ***I give permission** to leave a voicemail message at the following phone number:*

(Over)

Telehealth Services

Springfield Psychological offers Telehealth Services remotely using telecommunications technologies such as video conferencing. This allows our clients to engage in services without being in the same physical location and can be helpful when a client and provider cannot meet in person. While telehealth services allow for greater convenience in service delivery, there are risks in transmitting information over the internet that include, but are not limited to: breaches of confidentiality, theft of personal information, and disruption of service due to technical difficulties which may not be under the control of either my mental health services provider or myself.

Unless otherwise notified by Springfield Psychological, telehealth services may be a covered benefit under my insurance plan and co-pays and deductibles will apply. The same No-Show and Cancellation policies listed above remain in effect.

Documentation of telehealth services will be created and stored in the same EHR system as any note created from a face-to-face appointment/session. Such documentation falls under the same legal, professional, and contractual guidelines as any document stored as the result of a face-to-face appointment/session. As a patient, you will have access to information resulting from the telehealth service to the extent required by State and Federal law.

As a patient you have the right to withhold or withdraw consent to use telehealth in the course of your care at any time so long as it is provided in writing in accordance with State and/or Federal law without affecting your right to future care or treatment.

☐ *I am open and willing to engage in therapeutic services via telehealth and will discuss this option and the protocols involved, with my providers.*

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

I certify that I have read, understand and agree to the all of 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 available upon request).

_____ _____

Patient Signature (age 14 and above) Date

_____ _____

Parent /Guardian signature if patient is under 18 Date

Rev: 1/1/2019