# ACKNOWLEDGEMENT OF CLINIC POLICIES AND PRIVACY FORMS | MAPLEWOOD PSYCHOLOGY

**Client Name: _____ Clinician: _____ Date of Intake: _____**

*The purpose of this form is to obtain your consent to administer care and to share your health and personal information as necessary to process bills or claims, carry out functions that support treatment, and coordinate your care with other providers.*

## RESPONSIBILITY FOR PAYMENT

| | | | Initial |
|---|---|---|---|
| (1) | **Client Payments:** I agree to pay my copay at each session and understand I am ultimately responsible for payment for services received after insurance has processed claims (deductible and patient portion). I will notify the clinic if there are any changes in my health insurance coverage, home address, or phone number. I accept that I am responsible for Other Professional Services fees that are not covered by my insurance company if requested or required. | (1) | |
| (2) | **Insurance Payments:** I hereby authorize Maplewood Psychology to furnish to my insurance company all information that my insurance company may request concerning my present illness. I hereby assign to Maplewood Psychology the insurance proceeds to be credited against the total fee for services due on my account. I authorize Maplewood Psychology to correspond with the responsible party I designate regarding any outstanding balance due on the account. | (2) | |
| (3) | **Medical Assistance:** I understand that Maplewood Psychology is not a provider for MHCP Medical Assistance (Minnesota Health Care Programs, through the State of Minnesota), and instead, Maplewood Psychology is in network only for PMAP plans (Prepaid Medical Assistance Plans). I understand that I must notify Maplewood Psychology if my PMAP insurance lapses, and I cannot be seen again until it is re-instated. | (3) | |
| (4) | **Medicare:** I understand that Maplewood Psychology is not a provider for Medicare Part B. If I choose to be seen at Maplewood Psychology, I understand that I must prepay for services rendered. Maplewood Psychology will submit a claim on my behalf, and Medicare will reimburse me directly. | (4) | |

## CANCELLATIONS AND MISSED APPOINTMENTS

| | | | |
|---|---|---|---|
| (5) | I understand and agree to the 24-hour cancellation and missed appointment policy and accept responsibility for the fee of $100. | (5) | |

## EMERGENCY POLICY

| | | | |
|---|---|---|---|
| (6) | I understand that I can reach a therapist by calling the office during business hours, or by calling the answering service after business hours. I understand if my therapist is not available or on vacation, the on-call therapist will respond to my emergency. | (6) | |

## ELECTRONIC COMMUNICATION POLICY

| | | | |
|---|---|---|---|
| (7) | I have been informed of the office policies regarding electronic communication and will abide by its policies. I hereby give my informed consent to communicate with Maplewood Psychology via text:<br>Mobile Number _____<br><br>Email Address _____ | (7) | |
| **OR** (7a) | I DECLINE this form of communication. | (7a) | |

***(continued)***

## TELEHEALTH/TELEPHONIC TREATMENT

| | | | Initial |
|---|---|---|---|
| (8) | I have been informed of the office policies regarding treatment via telehealth or telephone and will abide by its policies. I hereby give my informal consent for the use of telehealth or telephone in my care. | (8) | |

## CONFIDENTIALITY

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|---|---|---|---|
| (9) | I have read and agree to the "Limits of Confidentiality" and understand their meanings and ramifications. | (9) | |

## NOTICE OF PRIVACY PRACTICES

| | | | |
|---|---|---|---|
| (10) | Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that I have certain rights regarding the use and disclosure of my Protected Health Information. I acknowledge that I have received a document outlining these rights. | (10) | |

## CONSENT FOR TREATMENT

| | | | |
|---|---|---|---|
| (11) | ***My initials and signature on this form, to be filed in my clinical record, indicate that I have read and understood the "Clinic Policies for Clients" and "Notice of Privacy Practices" regarding office policies, psychological practices, privacy practices, and confidentiality, and I give my informed consent to receive clinical services. I authorize my therapist to administer care and treatment to me, to perform diagnostic procedures and tests or other treatment considered necessary and advisable by my therapist. I understand there is a cost involved with these diagnostic procedures, assessment tools, and tests, and I am responsible for any portion not paid by my insurance company. My signature here, to be filed in my clinical record, indicates that I have read and understood this "Clinic Policies for Clients" and "Notice of Privacy Practices" regarding office policies, psychological practices, privacy practices, and confidentiality, and I give my informed consent to receive clinical services.*** | (11) | |

_____ _____ _____

**Signature of Client or Client Representative** **Printed Name** **Date**

*As the client's clinician, I have witnessed the client's consent to the above 11 topics. In the case of initial telehealth or phone appointments, the client has provided verbal consent for these 11 topics.*

_____ _____ _____

**Signature of Clinician** **Printed Name** **Date**