Maine Child Psychology
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MaineChildPsych.com

Notice of Consent to Psychological Services, Financial Responsibility, Assignment of Benefits, and Right to Privacy Notice

Patient Name: _____ **Date of birth:** _____

I. General Consent to Psychological Services and Right to Refuse Services

General Consent to Psychological Services: By signing below, I authorize Maine Child Psychology staff to conduct any diagnostic examinations, tests and procedures and to provide any treatment or therapy necessary to effectively assess, diagnose and treat my or my child's condition or illness. I understand that it is the responsibility of the psychologist with whom I meet to explain to me the nature of proposed care, treatment, services, interventions, or procedures, the potential benefits, risks, or side effects, including potential problems that might occur, the likelihood of achieving goals, reasonable alternatives, and the relevant risks, benefits, and side effects related to alternatives, including the possible results of not receiving care, treatment, and services, when indicated.

Right to Refuse Psychological Services: In giving my general consent to psychological services, I understand that I retain the right to refuse any particular examination, test, procedure, treatment, or therapy recommended or deemed necessary by Maine Child Psychology staff.

Education and Participation of Students and Trainees: I understand that Maine Child Psychology staff are dedicated to advanced psychology education, and that appropriately supervised students and trainees may observe and assist in my diagnosis, treatment and care, unless I expressly object to their participation in my health care.

Use of Videos and Photographs: I understand that video recordings and/or photographs may be utilized in my care for the purpose of diagnosis, documentation, education, or performance improvement. However, I understand that my specific, separate consent must be obtained before recordings, films or photographs that reveal identifying information will be made for external purposes or will be heard or seen by the public.

II. Acknowledgment of Responsibility for Payment and/or Assignment of Benefits

Please review with Maine Child Psychology staff the hourly rate and estimated total cost for psychological services to be provided. The scheduled charge for psychological treatment and evaluation services is $150.00/ hour. Billing for a psychological evaluation includes a charge for the time spent in direct patient care (for example, conducting interviews and testing), and also includes a charge for the time to score and interpret tests and to generate a written report. The scheduled charge for forensic evaluation and consultation is $250.00 / hour.

By signing below, I understand and acknowledge that I am financially responsible for paying all costs associated with the professional services I receive from Maine Child Psychology staff. I understand that I may be financially responsible for such costs even if I have health insurance, depending on the benefits and coverage limitations of my health insurance policy. I understand that I am also financially responsible for charges not covered by my health insurance, including deductibles, co-payments and non-covered services. I understand that health information about me, including (if applicable) information related to HIV/AIDS, substance abuse, and mental health treatment, may be shared with my health insurance carrier(s) or other third party payers responsible for paying for my health care. I understand that I may elect to bear the costs of my care privately if I do not wish certain sensitive health information disclosed to my third party payer.

By signing below, I authorize my health insurance carrier(s) or other third-party payers responsible for paying the costs of my health care, including Medicare, MaineCare (Medicaid) and TRICARE, to pay the costs associated with my health care directly to Maine Child Psychology.

Notice of Disclosure of Information When Psychological Services Are Provided to a Minor: A minor who consents to psychological services on his or her own behalf, but whose services are reimbursed under a parent's insurance policy, understands, and acknowledges that his or her parent will receive an Explanation of Benefits describing the nature of the services provided and that as a result such services may not be confidential.

III. Notice of Privacy Practices

I understand and acknowledge that Maine Child Psychology may use health information about me for purposes of treatment, payment, or health care operations. I understand that Maine Child Psychology may disclose health information about me, including mental health, substance abuse, and HIV/AIDS-related health information, when authorized by me or when otherwise required or authorized by law. I understand that a detailed list of permissible uses and disclosures is included in Maine Child Psychology's Notice of Privacy Practices. I understand that a copy of the Notice of Privacy Practices will be made available to me, and that I have the right to review it before signing this form.

By signing below, I acknowledge that I have been offered and have (check box that applies):

- ☐ **RECEIVED** a copy of Maine Child Psychology's Notice of Privacy Practices
- ☐ **DECLINED** a copy of Maine Child Psychology's Notice of Privacy Practices

Please note: Additional information about child and family rights, informed consent, confidentiality, access to records, and other topics is available in the booklet, "Rights of Recipients of Mental Health Services Who are Children in Need of Treatment", available at http://www.maine.gov/dhhs/ocfs/cbhs/policy/rights.shtml. If you believe you have a reportable grievance, you may file a complaint with the Office of Advocacy, Maine Department of Health and Human Services, 11 State House Station, Augusta, Maine 04333-0011

IV. Signature

By signing below, I hereby acknowledge that I have read the above information, that I understand and agree to the above statements, and that I have been given the opportunity to have any questions I might have addressed.
Signature of Patient, Parent, or Legally Authorized Representative

_____ _____
Date

If signed by a Parent or Authorized Representative, state legal authority of person to act on behalf of patient, e.g. parent of a minor, guardian, healthcare power of attorney agent, healthcare surrogate, etc.

Title: _____