Exceptional Services Group, LLC

Specialized Mental Health Therapy

Consent for Treatment

Consent to Treatment

I am voluntarily seeking psychotherapeutic services. I understand that I am responsible for my part in the therapy process, which includes providing honest information to my therapist, and follow therapeutic instruction and/or completing homework exercises. I realize that refusal to follow recommendations, being dishonest or withholding of information related to my problem could jeopardize my well-being. I understand that there are uncontrollable factors and that no guarantee is expressed or implied. If I feel the urge to hurt myself or someone else, I agree to contact my therapist, dial 911, call my physician or go to a hospital.

Confidentiality: It is our goal to provide a safe and supportive environment for all clients as they participate in therapeutic services. Your privacy is respected by keeping sessions confidential. Information about you is held in confidence by law and our policy is to never release information outside of sessions without your consent. Please be aware that state law and various court rulings require us to make a report to the proper authorities in one or more of the following circumstances:

- Suspected abuse, past or present, of a child under the age of 18 years.
- Suspected abuse of elders or dependent adults.
- Intention of serious and dangerous harm to self or others.
- When you waive your confidentiality. (For example, you waive your confidentiality when using your insurance company because your insurance company requires your information for payment or reimbursement of a claim.)
- When you voluntarily use your mental or emotional state in legal proceedings.
- Following a court order.

Additionally, if you have recently been under psychiatric and/or medical care, it may be necessary for us to consult with the treating physician for the purposes of diagnosis, treatment and continuity of care.

Records: Your clinical file will consist of legal forms such as this document, a record of visits and payments and clinical progress notes. These progress notes will contain enough information about your treatment to justify it, should justification ever become an issue.

Financial Responsibility/Assignment of Benefits:

I request that payment of authorized medical benefits be made on my behalf to Exceptional Services Group, LLC for services rendered to me of which assignment is accepted. I agree to pay all charges that are not paid in full by assignment. In order for this office to file insurance claims on your behalf, we must document your permission to give certain private information about you to your insurance or health care company. Typically, this includes the date of service and your diagnosis. Other data may be necessary from time to time in order to ensure that you receive the appropriate benefits. Some mental health treatments and diagnostic procedures are not covered by insurance. In that case you will be responsible for payment. Feel free to discuss your insurance coverage with our insurance department. Fees for services rendered to you are dependent on the type of service and the length of time involved. These fees can be discussed with our billing department at any time. You are responsible for any debt incurred for services rendered to you by your therapist.

I have read, understand and agree with all of the terms and conditions stated above.

_____

Print Client Name Client Signature Date

_____

Guardian (If Applicable) Guardian Signature Date

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Patient Intake/ Billing Information

PATIENT INFORMATION

Date:_____ Social Security#:_____

Patient's Name(Last):_____ Patient's Name (First): _____

Date Of Birth: _____ Gender: M or F (circle one)

Street Address:_____ City:_____

State:_____ Zip:_____

Home phone:_____ Work Telephone:_____

Cell phone:_____ Email Address:_____

May we contact you/ leave a message at the above number(s) _____Yes _____No

_____Home Only _____Office Only _____Cell Only

PATIENT CONTACT PERSON INFORMATION

Emergency Contact Person:_____ Relationship to Patient:_____

Phone:_____ Email:_____

Emergency Contact Name:_____ Phone:_____

LEGAL GUARDIAN/ PARENT/ GUARENTOR (if applicable)

Name(Last):_____ Name(First):_____

Relation to Patient:_____ Date Of Birth:_____

Social Security#:_____ Phone Number:_____

Street Address:_____ City:_____

State:_____ Zip:_____ Email_____

INSURANCE INFORMATION**MUST FILL THIS OUT

PRIMARY INSURANCE:_____
Phone:_____
Policy Number: _____
Group:_____
Policy Holder: _____
Relation to Patient:_____
Policy Holder's Date of Birth:_____
Policy Holder's SS#:_____
Employer:_____

SECONDARY INSURANCE:
Phone:_____
Policy Number: _____
Group Number:_____
Policy Holder: _____
Relation to Patient:_____
Policy Holder's Date of Birth:_____
Policy Holder's SS#:_____
Employer: _____

YOUR HEALTH CARE PROVIDER, INSURER, OR PLAN MAY REQUIRE A PHYSICIAN REFERRAL OR PRIOR AUTHORIZATION AND YOU MAY BE OBLIGATED FOR PARTIAL OR FULL PAYMENT FOR THERAPY SERVICES PROVIDED.

AUTHORIZATIONS and ACKNOWLEDGEMENTS

INSURED OR AUTHORIZED PERSON'S SIGNATURE: I authorize Exceptional Services Group, LLC to verify my insurance benefits and submit claims on my behalf. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby assign and request payment to be made directly to Exceptional Services Group, LLC for services rendered.

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE:

Print Name:_____

Signature:_____

Date: _____

"Signature on file" will automatically print on your claim form, allowing insurance to pay, directly.

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Receipt and Acknowledgement of Notice of Privacy Practices*

Privacy Practices are located at www.exceptional-wellness.com/forms/HIPAA

Patient/Client Name: _____

Date of Birth: _____

SSN: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Exceptional Services Group's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact:

Exceptional Services Group, LLC, 9070 Kimberly Blvd.- Suite 50, Boca Raton, FL 33434

Privacy Officer- Justin Vassi 561-852-0910

_____

Signature of Patient/Client **Date**

_____

Signature of Parent, Guardian or Personal Representative * **Date**

_____

* If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

☐ **Patient/Client Refuses to Acknowledge Receipt**:

_____

Signature of Staff Member **Date**