Willow Tree Center

Flexible ● Balanced ● Strong

PATIENT NAME: _____ **DATE OF BIRTH:** _____

1. CONSENT TO TREATMENT

I voluntarily consent to participate in mental health evaluation and/or treatment by licensed mental health professionals at Willow Tree Mental Health Center, LLC (Willow Tree Center). Evaluation and treatment may be administered with psychological interviews, psychological assessment or testing, psychotherapy, medication management, as well as expectations regarding the length and frequency of treatment. Possible benefits to treatment include improved cognitive performance, health status, quality of life, reduced feelings of emotional distress, and awareness of strengths and limitations, as well as fostering improved relationships. It should also be noted that treatment has potential risks. Since psychotherapy and other treatments often involve discussing difficult topics, I understand that I may experience uncomfortable feelings such as sadness, guilt, anger, frustration, loneliness, and helplessness. Treatment can sometimes provoke anxiety and can be disruptive to relationships. Of course, every individual's experience is different, and I understand Willow Tree Center makes no guarantees related to my treatment.

I understand that mental health evaluation and treatment is a collaborative relationship between me and my mental health professional and requires for me to take an active role, such as discussing my concerns openly and completing assignments. The relationship exists exclusively for therapeutic treatment and functions most effectively when it remains strictly professional, avoiding any type of social or business relationship.

As a patient of Willow Tree Center, I have the following rights:

- To be treated with consideration and respect for human dignity;
- To receive quality treatment regardless of race, religion, sex, age, ethnic background, or mental or physical disability;
- To be provided confidentiality and protection from any unwarranted disclosure of information regarding my treatment;
- To be involved in planning my treatment and informed about my treatment process;
- To be involved in my discharge and aftercare planning;
- To refuse treatment to the extent permitted by law and to be informed of the possible consequences of my actions;
- To examine and receive an explanation about the bill for my services; and
- To access the record maintained by Willow Tree Center about me and to receive any needed explanation about the contents.

The evaluation or treatment at Willow Tree Center will be conducted by a psychiatrist, a psychiatric nurse practitioner, or a licensed professional counselor. Treatment will be conducted within the boundaries of Missouri state law.

2. FINANCIAL RESPONSIBILITY; AUTHORIZATION & BENEFIT ASSIGNMENT

Fees for services provided at Willow Tree Center vary depending on the type of service, the provider, and maximum rates allowed by health insurance companies. A full fee schedule is available upon request - please submit a specific inquiry to Willow Tree Center.

I understand that I am responsible for full payment for the services I receive at Willow Tree Center at the time of service, unless I have made other arrangements in advance with Willow Tree Center. Willow Tree Center will help evaluate what resources and health insurance coverage I have to help pay for my treatment, but Willow Tree Center cannot make any guarantees that if I have health insurance, it will cover any or all of the services that I receive at Willow Tree Center. If I intend to use my health insurance for services provided at Willow Tree Center, I acknowledge that I am responsible for providing Willow Tree Center with all necessary information, such as my complete insurance identification information and any required preauthorization information.

I understand that my insurance benefits may not cover all charges and that I am responsible for those charges not covered by my health insurance. I also agree to pay any applicable co-payments at the time of service and coinsurance and/or deductibles.

I understand that if Willow Tree Center is not a participating provider in my health insurance plan, I will be responsible for paying for the services I receive at Willow Tree Center at the time of service; however, Willow Tree Center will supply me with a receipt of payment for services, which I can then

submit to my insurance company for reimbursement. Willow Tree Center cannot, however, make any guarantees that my health insurance company will reimburse me.

To the extent that Willow Tree Center is a participating provider in my health insurance plan, I assign and transfer to Willow Tree Center all insurance and other benefits and proceeds, including Medicare and Medicaid benefits and proceeds, to which I am or may become entitled as a result of Willow Tree Center's charges for services delivered to me or the person named above for whom I am the legal guardian or authorized representative. This transfer and assignment is made and shall be re-made as of the dates on which each benefit becomes payable to me. In connection with this assignment of benefits, I hereby transfer and assign to Willow Tree Center any right, title and interest that I have or may hereafter have to collect from any insurer, including Medicare and Medicaid, and authorize Willow Tree Center to submit a claim to such insurer or payer on my behalf.

I understand and agree that I may not be allowed to schedule a follow up appointment until my balance is paid in full or payment arrangements have been made. I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.

I understand that it is my responsibility to notify Willow Tree Center of any change in my insurance. I understand that this assignment of benefits will remain in effect until revoked by me (or my legally authorized representative) in writing.

3. AUTHORIZATION TO RELEASE INFORMATION

I understand that Willow Tree Center may have to disclose certain information to my health insurance company to receive payment, including my mental health diagnosis or treatment plans or summaries. By signing below, I consent to Willow Tree Center disclosing all necessary information to my health insurer for Willow Tree Center to receive payment.

4. CONFIDENTIALITY AND NOTICE OF PRIVACY PRACTICE ACKNOWLEDGMENT

In general, my communications with mental health professionals at Willow Tree Center and the records related to the services I receive from Willow Tree Center are confidential and can only be released with my written permission. However, there are exceptions to this general requirement. For instance, Willow Tree Center may disclose limited information when there is a clear risk of imminent harm to me or harm from me to others or to report current instances of child abuse or neglect. Willow Tree Center's policies about confidentiality, as well as other information about my privacy rights, are fully described in a separate document entitled Notice of Privacy Practices.

By signing below, I acknowledge that I have received a copy of Willow Tree Center's Notice of Privacy Practices, which explains how Willow Tree Center may use or disclose my protected health information.

5. CONTACTING WILLOW TREE CENTER AND EMERGENCIES

If I need to speak with my mental health professional at Willow Tree Center outside of my scheduled appointment time, I understand that I may send a confidential message by using the online patient portal, or leave a confidential voicemail message with my contact information, and my message will be returned. I understand that email is not a secure form of communication and that Willow Tree Center strongly discourages patients from using email to communicate confidential information to Willow Tree Center. Because patients may be scheduled back-to-back, I understand though that it is not always possible for Willow Tree Center to return a call immediately; however, Willow Tree Center will make every effort during its business hours that day to respond to me in a timely manner, with the exception of weekends and holidays.

I understand that Willow Tree Center does not provide emergency care. If I am experiencing a life-threatening emergency, I should call 911 or have someone take me to the nearest emergency room for help.

6. ATTENDANCE AND CANCELLATION POLICY

I understand the importance of consistently attending my scheduled treatment sessions and arriving promptly for my appointment. I acknowledge that I may be rescheduled if I arrive more than 10 minutes late for my scheduled appointment. I understand that it is my responsibility to schedule my appointments and that my scheduled times do not automatically roll into future sessions. I agree to provide at least 24 hours' notice when I need to cancel or reschedule an appointment. I understand that if I miss three or more appointments without providing 24 hours' notice, I may be dismissed from Willow Tree Center's practice.

I understand that if I do not show up for a scheduled appointment or do not cancel an appointment at least 24 hours in advance, I will be billed a no show/late cancellation fee of $60.00. I understand that insurance companies typically do not reimburse for no show or cancelled appointments, so I will be responsible for payment at my next scheduled appointment or I will be mailed a bill.

7. FORMS AND FEES

The fee for completing employment, disability, FMLA, camp or school permission forms, etc., is $10.00 per page. Any page which only requires a signature will be excluded from this page count.

I understand that I will be responsible for fees for completing forms. I must pay these fees before I will be able to receive the completed form. My portion of the form must be completed and signed prior to submitting the form to Willow Tree Center.

8. PRESCRIPTION MEDICATION POLICIES

I understand that prescription refills generally require at least 48 hours' advance notice (2 business days), whether they are written, sent electronically, or called into a pharmacy. Medication refills will typically only be provided during normal office hours on weekdays. A refill request must include the name and dosage (number of milligrams) of the medication, the current directions provided by the prescriber, and the name and telephone number of the pharmacy.

I understand that it is my responsibility to request prescription refills before I run out of medication. All prescription medications require regular follow-up appointments to ensure patient safety. The frequency of follow up is determined by the prescriber. In order for refills to be provided, I understand that it is expected that I have a follow-up appointment scheduled as advised by the prescriber. I understand that the prescriber has sole discretion in determining whether or not to provide a prescription refill.

SIGNATURE FOR CONSENT

By my signature below, I acknowledge that I have read, understand and agree to the terms and conditions contained in Sections 1 through 8 above. I have been given appropriate opportunity to address any questions or request clarification for anything that is unclear to me. I am voluntarily agreeing to receive services and treatment from Willow Tree Center (or for my child or ward to receive services and treatment from Willow Tree Center), and I understand that I may stop such treatment or services at any time.

Printed Name of Patient/Guardian/Responsible Party:_____

Signature of Patient/Guardian/Responsible Party:_____ Date:_____

If Guardian/Responsible Party, description of authority: _____