Kissel Hill COUNSELING ASSOCIATES, LLC

100 Highlands Drive, Suite 103 Lititz, PA 17543
Phone (717) 625-0015 | Fax (717) 625-0009
contact@kisselhillcounseling.com
www.kisselhillcounseling.com

Informed Consent

Client Name _____ Date of Birth _____

After reading this carefully, please indicate your understanding and consent by signing your name and date in the space provided. If you have any questions, please feel free to discuss them with your therapist. Your signature below serves as authorization for outpatient therapy services. This authorization has been made freely and voluntarily. You may request a copy of this signed document.

Confidentiality- Any diagnosis, evaluation, treatment, or referral that is collected regarding the client is considered Protected Health Information (PHI). Also included is any identifying information, contact and insurance information. This information is necessary to provide the best treatment for the client and needed to arrange payment for your treatment. The information shared with the therapist will be kept confidential and private, and is privileged communication between the client and the therapist. This means, without permission of the client (parent or legal guardian if the client is younger than 14 years), no information will be released or shared to anyone outside of this organization. The exception of this policy is a situation in which there is reasonable suspicion of imminent danger to the client or to someone else, a situation in which there is reasonable suspicion or report of child abuse, or if the information is court mandated by a direct court order. In these instances, as per Pennsylvania Law, notification must be made to the proper authorities. Information may be shared from your record, upon written request, with other agencies and/or individuals. Kissel Hill Counseling Associates, LLC reserves the right to assess a fee for records being shared, with the exception of when they are being faxed directly to another agency.

Health Insurance- Many insurances are accepted by the provider. However, it is up to the client (or financially responsible party) to be aware and informed of the terms of the specific plan(s) being offered, and to be prepared to provide any and all information that is necessary for the timely filing of insurance claims. Co-payments and/or coinsurance are contractually agreed upon by the member or policy holder, and must be collected by the provider at the time the service is rendered. If client is unable to make such payment, a $15.00 fee will be assessed, in addition to the regular fees; such fees are required to be paid prior to the next session taking place. Each client (or financially responsible party) is ultimately responsible for the payment of service fees. For unpaid balances that are not collected, despite attempts made to do so by the provider, may be turned over to a collection agency (including any collection fees applied at the time and need for this action).

Emergencies- The nature of private practice outpatient therapy, at times may mean that the therapist is not easily available. In the event of a mental health or medical emergency, please do not wait for the provider. The client (parent/legal guardian) should contact Crisis Intervention at (717) 394-2631, call 911, or go to the nearest Emergency Room for care and treatment.

Custody of Parents/Guardians- We may require the consent of both parents/guardians to assess and treat your child.

1. Do you have the Legal Right to consent to medical decisions for this client? ☐ Yes ☐ No
2. Is there a current custody agreement that outlines your parental rights? ☐ Yes ☐ No *-if yes, documentation is required*

I have read this form and understand and consent to the policies and responsibilities stated therein.

_____	_____	_____
Client Signature	Printed Name of Client	Date Signed
_____	_____	_____
Signature of Mother	Printed Name of Mother	Date Signed
_____	_____	_____
Signature of Father	Printed Name of Father	Date Signed