MaryEllen Agolia, PhD, LLC
P.O. Box 351
High Rolls, New Mexico 88325
Phone: (575) 430-4115
Fax: (866) 591-1508

CONSENT FOR TREATMENT

This contract explains the conditions agreed upon when obtaining services with MaryEllen Agolia, PhD. Some of these rights and obligations are imposed by state and federal law while others are established through contractual agreement. Any questions should be discussed prior to initiation of treatment. Your signature signifies your consent in its entirety.

Client Name:_____ Date of Birth:_____ SS#:_____
Address:_____Home Phone:_____
_____Other Phone:_____

It is □ acceptable □ NOT acceptable for a representative of MaryEllen Agolia, PhD to leave a message with someone or on a voicemail at the number(s) listed above.

EMERGENCY CONTACT:
Name:_____ Phone Number:_____

PLEASE INITIAL EACH LINE:

_____I do hereby consent to treatment with: MaryEllen Agolia, PhD. In case of a minor client, I acknowledge that I am the legal custodian and can legally consent to treatment. Should legal custody change following the onset of treatment, I agree to notify Mary Ellen Agolia, PhD immediately.

_____The office of MaryEllen Agolia, PhD is authorized to use the contact information outlined below for appointment reminder calls and written correspondence. Additionally, I understand that I will be required to provide written notification if I desire to change or revoke consent.

CONFIDENTIALITY

Please see the *Notice of Privacy Practices* posted in the office waiting area or request a personal copy.

CHILD AND ADOLESCENT

In the case where the identified client is a minor, authorization is granted by a legal guardian for the provision of diagnostic and therapeutic services by MaryEllen Agolia, PhD. Further, the involvement of the significant individuals in a child's life is frequently necessary for positive change. The guardian(s) agree to participate in treatment and assist in getting other significant individuals in the child's life to participate as well.

FAMILY, GROUP AND COUPLE THERAPY

Unless otherwise specified, when multiple individuals with a common bond or relationship are seen in therapy together, one person is established as the "client" and becomes the relationship that binds the individuals together. Clinical and financial record keeping (i.e. session notes & insurance claims filing) follows one individual as "the client." Confidentiality applies to participants of family, group, and couples therapy as it applies to Dr. Agolia as the counselor. Each participant is then responsible for confidentiality of the family, group, or couple. Please discuss any questions or concerns with Dr. Agolia. Individual therapy for any of the participants is available by referral.

ACCESSIBILITY

MaryEllen Agolia, PhD is available to clients by telephone on an as-needed basis. If an immediate or life-threatening emergency arises, call 911. The client or guardian should also call the office to reach MaryEllen Agolia, PhD at (575) 430-4115 during and after business hours. This phone is equipped with a voice messaging system.

REASONABLE EXPECTATIONS

MaryEllen Agolia, PhD will execute her professional knowledge and skills in every effort to assist in obtaining the client's specific objectives. Therapeutic services are individual in nature and dependent upon client participation.

COORDINATION OF CARE WITH PRIMARY CARE PHYSICIAN (check one box)

I hereby authorize MaryEllen Agolia, PhD:

□ To release any applicable information to my Primary Care Physician:
Physician Name:_____ Phone:_____ Fax:_____

□ **NOT** to release information to my Primary Care Physician.

FINANCIAL CONDITIONS

Office policy is to charge usual and customary fees for therapeutic and psycho-educational services provided. The client or responsible party (if client is a minor) is ultimately responsible for the fee at the time that services are rendered. This fee may be adjusted when (a) A special rate has been negotiated with a third-party payor (i.e., insurance company, HMO, PPO), (b) No or very limited insurance coverage exists.* or (c) Existing coverage has been exhausted.****In these cases, a rate is negotiated on a "sliding scale" based on verifiable financial hardship.**

APPOINTMENT SCHEDULING AND CANCELLATIONS

If the client or responsible party has reserved an appointment and chooses for any reason not to utilize that time, twenty-four (24) hours notice is required. This allows sufficient time to offer the time slot to another client who may be awaiting an opening. If inadequate notice is given or a client misses an appointment that he or she has reserved, the responsible party will be held financially liable for the reserved appointment. This fee will be based on the contracted rate per session and charged at 50% of that rate, not the co-payment.

PHONE CALLS BETWEEN SCHEDULED APPOINTMENTS

MaryEllen Agolia, PhD is available for telephone consultation if/when an emergency issue may arise prior to the next scheduled appointment.

LETTERS, FORMS AND MISCELLANEOUS PAPERWORK

All written correspondence requested or required to be completed will be charged based on the therapist's hourly appointment rate.

DELINQUENT OR INSUFFICIENT PAYMENT

Payment is expected to occur at the time that services are rendered. Any returned check fees will be forwarded to the guarantor and will be charged at a minimum rate of $50 per occurrence. If an outstanding guarantor balance should develop, sessions will be interrupted until the outstanding balance is rectified.

Having discussed your financial situation and terms, we both agree to the terms above and the following fee arrangements:

☐ Private pay fee of $_____ per session OR ☐ Insurance plus co-payment of $ _____per session*

(If applicable) Payments toward deductible: $ _____per session for first sessions.

***While the office of MaryEllen Agolia, PhD will assist in determining the limits of insurance coverage, the client or responsible party is expected to understand his/her own insurance coverage and required to guarantee payment for services utilized.**

*SIGNATURE ON FILE:

I authorize the release of any payment and clinical information necessary to process claims made on my behalf or that of my family member. Please accept a photocopy of this authorization as if it were an original. My signature below acts as a signature on file.

Signature:_____ Date_____

*ASSIGNMENT OF BENEFITS:

I hereby authorize direct payment of insurance benefits to MaryEllen Agolia, PhD for professional services rendered. I understand that I am financially responsible for all charges not covered by this assignment.

Signature:_____ Date_____

I understand that my records are protected under the applicable state law governing healthcare information that relates to mental health services and under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records 42 DRF Part 2, and cannot be disclosed without my written consent unless otherwise provided for in state or federal regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. This release will automatically expire at the end of treatment and the close of the financial file of the client.

_____	_____	_____
CLIENT OR GUARDIAN SIGNATURE	***PRINTED NAME***	***DATE***
_____	_____	_____
WITNESS SIGNATURE	***PRINTED NAME***	***DATE***