



Family SOS, Inc.

CONSENT FOR TREATMENT

Services

Family SOS, Inc provides outpatient counseling services to individuals, couples, families. We **DO NOT** offer crisis or emergency services. If you feel you are in a crisis you are advised to go to your closest hospital emergency room or call 911. Our therapists are available by phone however we cannot guarantee that you would receive a timely response back from your therapist during a crisis.

Initials: _____

Confidentiality

The topics discussed in session, in paperwork, emails or phone calls will not be shared with anyone unless you have given us written permission to do so. If you wish to have information shared with another party, You will be required to sign a *Release of Information* form to do so. However, there are three exceptions to this policy as mandated by law:

1. Child or elder abuse is disclosed
2. Believable threat that client will attempt to harm self
3. Believable threat that client will attempt to harm others

Initials: _____

Financial Policy Agreement

Payment in full is due at the end of each session unless a prior arrangement has been agreed upon Teresa Petersen Mendoza, owner of Family SOS, Inc. Family Sos, Inc accepts checks, cash and credit card. You are responsible for all charges for professional services rendered on behalf of the identified client. Including any collection, attorney fees or court costs associated with the use of outside agencies required for collection of your account.

Fees

*Intake Session \$160

*Individual Session \$140

*Cancellation < **48hr notice** \$50.00

*No Show Fee \$140

*Report Writing (60 min) \$120

*Returned check / chargeback fee \$50.00

*Court Involvement \$150 / hour

*Outside Collections \$50.00

Clients are required to have a current credit card on file at Family SOS, Inc. A copy of your current credit card will be kept in your general file. Any fees associated by checks returned to Family SOS, Inc by your bank for insufficient funds will be billed to the client and an alternate method of payment will be required.

Statements / bills will be provided by request. Questions about bills should be directed to our business office. Balances are due upon receipt of invoice unless other arrangements are made. If a bill is not paid after the second statement, Family SOS, Inc, has the right to run the Credit card on file for the unpaid Balance. Unpaid balances may be referred to an outside agency for further attempts to collect. Accounts referred outside Family SOS, Inc are assessed a fee.

Initials: _____



Family SOS, Inc.

Cancellations

I hold your appointment time specifically for you. Because of this, a **48-hour notice** is required for any cancellations. Clients will be billed for sessions cancelled without a **48-hour notice**. It is important to keep your scheduled appointment times to ensure quality therapy and progress.

Initials: _____

Insurance

Third-Party Payors : Family SOS, Inc agrees to file insurance or managed care claims on behalf of the client one time for each date of service. However, filing does not release client from responsibility for payment. Claims not paid within (60) days of filing become the responsibility of the client. If payment from the third-party payor is received after the client has paid the balance, the client will be reimbursed. I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s) and providers of any services or treatments I receive. I authorize the release of necessary information to my insurance company or EAP so that Family SOS, Inc may pursue payment for services rendered to me. If payment is not received within 60 days of services, Family SOS, Inc is authorized to bill my credit card on file.

Initials: _____

Co-payments/ Co-Insurance : Most third-party payors require a co-payment or co-insurance fee from the client. This fee is due at time of service. Co-payments are initially quoted from your insurance company and may not be accurate. Family SOS, Inc will not be held responsible for inaccurate quotes from the insurance companies. Accurate co-pays may not be known until claims are returned. Clients are responsible to pay any additional co-pay costs if indicated at that time. Clients using Employee Assistance (EAP) services must supply the Employee Assistance Program managing company, authorization number and contact information at the time of the initial session.

Deductible: Clients will be charged their deductible when applicable. This amount may be unknown until the first claim is processed. Clients will be charged at that time.

Initials: _____

Electronic Communication

There are times when we may communicate by phone, text, email or Skype. While we will do our best to keep all communication private, please, be aware that electronic communication is not completely secure. Thus, you agree to not hold Family SOS, Inc responsible for any information that may be compromised.

Initials: _____

I have read and understood all of the above information

E-Signature (if under 12, Parent/Guardian Signature)

Date



Family SOS, Inc.

FINANCIAL AGREEMENT

I understand that the fees for sessions that are cancelled in **less than 48 hours or a no show** to a scheduled appointment are billed in the same week to me.

If I have an unpaid balance I understand that I will be charged and am responsible for paying any associated charges and fees.

E-Signature to acknowledge

Date

NOTICE OF PRIVACY PRACTICES FOR FAMILY SOS, INC

I have received the notice regarding my Personal Health Information use and disclosures. I have reviewed the Medical Records Privacy Act Notice for Family SOS, Inc. in its entirety and have been offered a copy of this document.

PLEASE NOTE: In order to avoid confusion or misunderstanding, we ask that if you wish to exercise any of the rights enumerated in the Privacy Policy, that you put your request in writing and deliver or send the writing to us. If you wish to learn more detailed information about any of the above rights, or their limitations, please let me know. We are willing to discuss any of these matters with you.

Date: _____

Name: _____ E-Signature: _____

Name: _____ E-Signature: _____