2017

INFORMED CONSENT

Thank you for choosing Thelma A. Costello, MS, LMHC, PC. Today's appointment will take approximately 45-50 minutes. We realize that starting counseling is a major decision and you may have many questions. This document is intended to inform you of our policies, State and Federal laws and your rights. If you have other questions or concerns, please ask and we will try our best to give you all the information you need. Thelma Costello, MS, LMHC has earned a Bachelor of Arts Degree in Sociology and a Masters Degree in Psychology and Addictions from the University of Capella. She is licensed by the State of New York as a licensed Mental Health Specialist. She has over 35 years of clinical experience in treating adolescents, adults, and families using individual and family therapy for most conditions. Although other treatment approaches are used depending on the person or condition. Treatment practices, philosophy and plan imitations and risks will be discussed with you today.

CONFIDENTIALITYAND EMERGENCY SITUATIONS : *Your verbal communication and clinical records are strictly confidential except for : a) information shared wit our staff psychiatrist, b) information (diagnosis and dates of service) shared with your insurance company to process your claims, c) information you and/ or your child or children report about physical or sexual abuse; then by New York State Law, I am obligated to report this to the Department of Children and Family Services, d) where you sign a release of information to have specific information shared and e) if you provide information that informs me that you are in danger of harming yourself or others f) information necessary for case supervision or consultation and g) or when required bylaw. If an emergency situation for which the client or their guardian feels immediate attention is necessary, the client or guardian understands that they are to contact the emergency services in the community (911) for those services. Thelma Costello will follow those emergency services with standard counseling and support to the client or the client's family.*

Signature (s)_____ Date_____

FINANCIAL/ INSURANCE ISSUES*:* *As a courtesy we will bill your insurance company, HMO, responsible party or third party payer for you if you wish. We ask that at each session you pay your co-pay or 50% of the fee. In the event you have not met your deductible, the full fee is due at each session until the deductible is satisfied. If your insurance company denies payment or does not cover counseling, we request that you pay the balance due at that time. If your balance exceeds $300.00 we will need to ask that you pay for services when rendered. After 60 days any unpaid balance will be charged 1.5% interest a month (18% APR). In the event that an account is overdue and turned over to our collection agency, the client or responsible party will be held responsible for any collection fee charged to our office to collect the debt owed. We ask that every client authorize payment of medical benefits directly to Thelma Costello.*

I have received a copy of my fee schedule _____

Lastly, if you need to cancel or reschedule an appointment, please give 24 business hours advance notice, otherwise you will be billed at hourly rate. We sincerely appreciate your cooperation and at any time you have any questions regarding insurance, fees, balances or payments please feel free to ask.
You may have a copy of this form if requested.

Signature(s)_____Date_____

COORDINATION OF TREATMENT: *It is important that all healthcare providers work together. As such, we would like your permission to communicate with your primary care physician and/or psychiatrist. Your consent is valid for one year. Please understand that you have the right to revoke this authorization, in writing at any time by sending notice. However, a revocation is not valid to the extent that we have acted in reliance on such authorization. If you prefer to decline no inform will be shared.*

You may inform my physician(s) **I decline to inform my physician(s)**

PHYSICIAN
NAME: _____
CLINIC: _____
ADDRESS: _____
PHONE: _____

Signature(s)_____Date_____

CONSENT FOR TREATMENT OFCHILDREN ORADOLESCENTS:
I/ We consent that _____ may be treated as a client by Thelma Costello. At times it maybe necessary to schedule appointments during school hours. We ask for your cooperation to provide the most timely treatment for you and your children.

Signature(s)_____Date_____