Consent for Treatment

Welcome to **Red Bird Mental Health Services, Inc. (RBMH)**. This document contains important information about our professional services and business policies. Please review it carefully. Write down any questions you may have so we can discuss them during your next session. By signing this document, you agree to the terms outlined herein.

Psychological Services

Psychotherapy is a collaborative process that varies depending on the therapist's and client's personalities and the specific issues being addressed. Unlike a medical doctor's visit, psychotherapy requires active participation both during sessions and at home.

Potential Benefits and Risks

Psychotherapy may include discussing difficult or unpleasant aspects of your life, which can sometimes lead to feelings of sadness, guilt, anger, or frustration. However, therapy can also result in may benefits including:

- Improved relationships
- Resolution of specific challenges
- Reduction in feelings of distress

While many clients benefit from therapy, there are no guarantees of specific results.

Initial Evaluation and Treatment Planning

Your first several sessions will involve an evaluation of your needs, after which your therapist will provide initial impressions and propose a treatment plan. Therapy requires a significant commitment of time, money, and energy, so it is important that you feel comfortable with your therapist. If you have concerns, your therapist can refer you to another mental health professional for a second opinion.

Collaborative Case Management

RBMH therapists often collaborate to ensure high-quality care, particularly for cases referred by **Luzerne County Children and Youth Services (LCCYS)**. Case information is shared internally for supervision and consultation. LCCYS also requires monthly updates, including dates of service, therapy goals, and progress. If you have questions about this process, please speak with your therapist or contact the agency director, Dr. Megan Velo-Zorzi.

Appointments and Attendance

- Therapy sessions typically last 45–60 minutes and occur weekly, although frequency may vary.
- Please provide **24 hours' notice** if you need to reschedule. Failure to do so will result in a **$25 no-show fee**.

Billing and Payments

Session Fees and Additional Services

If you choose to bill your insurance company for services, you are responsible for:

- Providing updated and accurate insurance information.
- Understanding your financial responsibility, including copays, deductibles, or any other fees not covered by insurance.

You agree to allow us to release any pertinent information required by your insurance company for billing purposes. This may include, but is not limited to, identifying information, diagnosis, dates of service, diagnostic intake, and treatment plans.

If you opt to pay out of pocket, please refer to the *Good Faith Estimate* for an itemized list of estimated costs associated with services.

Additional Professional Services

Services beyond standard therapy sessions are billed in 15-minute increments and include, but are not limited to:

- Report writing.
- Phone calls exceeding 10 minutes.
- Attendance at meetings with other professionals.
- Preparation of treatment summaries.
- Other requested services.

Victim Compensation Fund

- If you utilize the **Victim Compensation Fund**, it may cover some counseling costs, however there is no guarantee that they will approve the claim.
- It is your responsibility to follow up with Victim's Compensation for any required documentation needed to approve the claim.
- Once the fund is depleted or if a claim is denied, you are responsible for any remaining balance.

LCCYS Referrals

- Counseling fees are covered by LCCYS as long as you or your family remain active with their services.
- Once you are no longer active with LCCYS, you are responsible for all fees, including co-pays, co-insurance, and deductibles.

Payment Policies

- **Insurance**: You are responsible for any fees not covered by your insurance, including:
    - Services excluded from your plan.
    - RBMH being an out-of-network provider.
    - Inaccurate or incomplete insurance information.
- In cases of financial hardship, fee adjustments or payment plans may be available.

Legal Proceedings

- If your therapist is called to testify at your request:
    - A flat fee of **$640** covers the first four hours (including preparation, travel, and testimony).
    - Each additional hour is billed at **$160**.
- If legal proceedings involve **LCCYS**, they are responsible for covering the therapist's costs.

Delinquent Accounts

- Accounts unpaid for more than **60 days** without an arrangement may be sent to collections or resolved in small claims court.
- Legal costs will be included in any claim.

Contacting Your Therapist

Your therapist may not be immediately available due to client sessions. Please leave a voicemail or email, and they will respond within **24–48 hours**, excluding weekends, holidays, or vacation.

Emergency Contacts
If you are in crisis, please contact:
- **Helpline of NEPA**: **2-1-1 or 1-855-567-5341**.
- **Suicide Prevention Hotline**: **9-8-8**
- Hazleton and Lower Luzerne County - Northeast Counseling Services: 570-455-6385
- Nanticoke - Northeast Counseling Services: 570-735-7590
- Tunkhannock/Wyoming County - The Robinson Center: 570-836-2795, The Burke Center: 570-240-4774, and Northeast Counseling Services: 570-735-7590

For immediate emergencies, call 9-1-1 or go to the nearest emergency room:
- **Commonwealth Health Wilkes-Barre General Hospital**: 570-829-8111
- **Geisinger Hospital**:
    - South Wilkes-Barre 570-808-8780
    - Geisinger Wyoming Valley Medical Center 570-808-7300

Professional Records

RBMH maintains confidential treatment records as required by law. You may request a copy or summary of your records. A fee may apply for time spent preparing records.

Record Fees (as of January 1, 2019):

- Pages 1–20: **$1.55 per page**
- Pages 21–60: **$1.55 per page**
- Pages 61+: **$0.39 per page**
- Microfilm copies: **$2.20 per page**
- Records for Social Security or financial aid claims: **$29.19 flat fee**
- RBMH charges **$0.05 per page** for client-requested copies.

Confidentiality

All communications with your therapist are confidential except in the following situations:

1. **Court-Ordered Disclosure**
   If a court orders the release of information, your therapist is legally required to comply.
2. **Mandated Reporting**
   Your therapist is a mandated reporter, which means they are legally required to report suspected abuse or neglect of a child, elder, or disabled person to the appropriate agency. This obligation applies even if the individual at risk is not a client of our agency. Additionally, if someone discloses that they have harmed a minor, your therapist must report this, even if the minor is not a client of our agency.
3. **Threats of Harm**
   If a client threatens harm to themselves or others, your therapist is required to take protective actions. These may include notifying the potential victim, contacting law enforcement, or seeking

hospitalization for the client. If a client is at risk of self-harm, hospitalization may be required, and your therapist may contact family members or a designated emergency contact for support.

4. **Malpractice Lawsuit Defense**
   If a therapist is involved in a malpractice lawsuit, confidentiality may be waived as part of their legal defense.
5. **Administrative Communication**
   RBMH may use email or text messaging for non-clinical matters, such as scheduling. These communication methods are not secure, so please refrain from sharing sensitive or clinical information through these channels.

Your therapist will make every effort to discuss any potential disclosure with you, except in situations where it is not possible or permitted by law.

Authorization for Payment

By signing this agreement, you authorize payment to RBMH and accept financial responsibility for any services not covered by insurance.

Your signature indicates that you have reviewed this document and agree to its terms.

Name (Print): _____

Signature: _____

Date: _____

For Parent/Guardian (if applicable):

Name (Print): _____

Relationship to Patient: ☐ Parent ☐ Legal Guardian

Signature: _____

Date: _____