KINGS COUNSELING CENTER

808 N. IRWIN STREET
HANFORD, CA 93230
559-584-2819
Roger A. Watson, M.F.T., and Associates
Marriage, Family and Child Therapist
Psychotherapy

For Office Use
Patient ID#_____

PATIENT CONSENT FORM

PATIENT NAME: _____ **DOB**: _____ **AGE**: _____
Form to be completed by patient (or parent/guardian if patient is under the age of 18)

FINANCIAL TERMS: Upon verification of health plan/insurance coverage and policy limits, we will bill your insurance carrier for you and your provider will be paid directly by the carrier. You (patient or guardian) will be responsible for any applicable deductibles and co-payments. If you are not eligible at the time services are rendered, you are responsible for payment. Co-payments are expected to be paid at the time services are rendered. If you are without health plan/insurance coverage, payment arrangements should be made prior to your first appointment. A billing fee of $1.50 will be charged monthly for unpaid balances. Our records indicate that your benefit has a co-pay of $_____ **INITIAL** _____

CANCELLATION/MISSED APPOINTMENTS: A scheduled appointment means that time is reserved only for you. If an appointment is missed or canceled ***with less than 24 hours notice, you will be billed*** according to the scheduled fee or according to the rules of your health plan. Frequent cancellations may result in the termination of your treatment; your compliance in keeping appointments and active participation in the treatment process are vital. **INITIAL _____**

EMERGENCIES: If you are in imminent danger call 911, or your nearest police department or emergency room. Your provider's policy regarding emotional crises and his/her availability/policy should be discussed during your first appointment. If you are truly experiencing a psychiatric crisis and cannot reach your provider directly, you should consider contacting the behavioral health/mental health phone number on your insurance card and ask to speak to an On Call clinician.
INITIAL _____

CONFIDENTIALITY: All information between therapist and patient is held strictly confidential unless:

1. You authorize release of information with your signature (or parent/guardian)
2. You present a danger to others
3. You present a physical danger to self
4. Child or elder abuse is suspected

In the latter two cases, we are required by law to inform potential victims and legal authorities so that protective measures can be taken. **INITIAL _____**

INTRA-ORGANIZATIONAL CONSULTATIONS: Kings Counseling Center operates from a team approach in that intra-organizational consultations may be conducted within the counseling staff. While identity may be disclosed to staff members, no person outside the staff will have access to patient identity or records. **INITIAL _____**

RELEASE OF INFORMATION TO THE HEALTH PLAN: I acknowledge that my Health Care Plan may require the release of information including a treatment plan for claims in order to process claims, recertification, case management, quality improvement, and for other purposes related to the benefits of my Health Care Plan. I have received a copy of the "NOTICE OF PRIVACY PRACTICES." **INITIAL _____**

I understand and agree to the above:

Patient/Guardian's Signature _____ Date _____

Witness Signature _____ Date _____