Grandview
Therapy and Consulting

Grandview Therapy and Consulting, LLC
(719) 505-2461
615 N. Nevada Ave, Unit 4
Colorado Springs, CO 80903
grandviewtherapyandconsulting.com

Consent to Treatment and Services Contract

Welcome. The decision to seek therapy is important and personal, and it can sometimes be uncomfortable, not quite knowing what to expect. This document is designed to help you understand more about therapy and what it might be like to work with me.

Therapy is a unique process, one that aims to guide you through challenges and roadblocks, helping you move towards health and authenticity. My goal is to create a space where change is possible, a space where growth is safe and cultivated. Using an evidence-based approach, I work to help you gain awareness of your emotional experience, working together to understand this and the way you experience and interact with the world. I work to help you identify and explore parts of yourself that you may not be completely comfortable with, learning to tolerate discomfort that surfaces in the process. I will challenge you to try something different towards creating a healthier and more balanced way of living. I encourage you to communicate openly about your experience in therapy, bringing up any questions or concerns you have with me.

Consent to Treat: I consent to and authorize Grandview Therapy and Consulting, LLC (further referred to as the practice) and its healthcare team to perform psychological evaluation and treatment as deemed medically necessary and in their professional judgment.

Confidentiality: I understand that my records will be held in confidence according to the Colorado Revised Statutes [CRS section 12-43-218, the code of Federal Regulations 42 C.F.R. Part 2) and the practice's Notice of Privacy Practices. Exceptions to the rule of confidentiality, such as danger to self, danger to others, grave disability, child or elder abuse or neglect, court order, acts of terror, or in response to any legal action taken by you against the practice, among others, may arise during the course of treatment.

Destruction of Records: I understand that the clinical records may be destroyed if no further treatment is rendered within 7 years of the date of termination of the episode of treatment. Pediatric records are destroyed 7 years after turning 18 regardless of treatment termination date.

Assignment of Benefits and Release of Information: I agree to be responsible for my co-payment, deductibles, or other charges for services not covered by insurance or other third-party payors except as prohibited by any agreement between my insurance company and the practice or by state or federal law. I authorize the practice to file any claims for payment of any portion of my bill and assign all rights and benefits payable for services to the practice C until final payments are made. I authorize the practice to release any information necessary, including mental health/substance abuse records, to process claims as required by my insurance company or third-party payors until final payments are made.

Communication Consent: You may contact me via phone ((719) 505-2461) or email (drbenjaminneale@gmail.com). While I am often not available for immediate contact, I do my best to check voicemails and messages regularly throughout business hours, returning contact within 48 hours. Only direct phone calls, letters, and communication via the patient portal are subject to the most stringent security protections under the HIPAA Privacy Rule. If I choose to communicate with my provider by email, text message, Skype, Facetime, or if my provider deems in-vivo exposures necessary, I acknowledge and accept the risk of inadvertent disclosure of my own Protected Health Information due to less stringent security protections. 45 C.F.R § 164.522(b): A covered health care provider must permit individuals to request and must accommodate reasonable requests by individuals to receive communications of protected health information from the covered health care provider by alternative means or at alternative locations.

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Emergencies: I am typically not available outside of business hours. If you have an emergency, please call 911 or go to your nearest Emergency Department. If you are feeling suicidal, you can also contact the Colorado Crisis Services at 1-844-493-8255, which is typically available 24/7.

Client Financial Responsibility:

- ☐ I wish **NOT TO** file insurance:

I am choosing to opt out of filing in-network insurance for my treatment with Grandview Therapy and Consulting, LLC. I acknowledge that if I change my mind, I **CANNOT** request Grandview Therapy and Consulting, LLC to back bill my insurance company for services already rendered. I understand that I am eligible for a self-pay sliding scale by choosing this option.

All fees are due at the time of service. I understand that Grandview Therapy and Consulting, LLC (further referred to as the practice) may revise the fee schedule at any time. I agree to pay all costs including reasonable attorney fees in the event the practice refers unpaid fees for collection. If and when there are changes to my financial situation that will impact my financial obligations, I will notify the practice and make alternate financial arrangements for services. Failure to honor financial obligations may result in discharge from the practice.

- ☐ I wish **TO** file insurance:

I am choosing for Grandview Therapy and Consulting, LLC to file insurance on my behalf to my insurance company, I have provided my insurance card (or informed biller of benefit details) and will keep my insurance information up to date all times. I am aware my payer will require information such as a diagnosis, type and cost of service, dates of service, treatment plan, etc. Insurance companies can also require copies of Grandview Therapy and Consulting, LLC notes in some circumstances. I understand that my insurance company, will only cover treatment they deem to be **MEDICALLY NECESSARY**. I am requesting Grandview Therapy and Consulting, LLC to file my insurance.

Your insurance is an agreement between you and your insurance company, not between your insurance company and my office. When possible, I will call to verify benefits on your insurance; however, the benefits quoted to me by your insurance company are **NOT A GUARANTEE OF COVERAGE or PAYMENT**. As a courtesy to you, my office will complete any necessary insurance forms at no additional charge, and file them with your insurance company to help you collect. It is to be understood and agreed that you are personally responsible for payment of any non-covered services, deductibles or co-pays. You may then submit the bill to your insurance carrier for reimbursement.

Self-Pay Fee Schedule Therapy Services: Initial evaluation 60 minutes: $200; Therapy sessions 50 minutes: $140.

Urgent Appointments: Urgent Appointment (within 24 hours of contact) 150% of session fee.

Failure to Pay: Late Fee (after 30 days of balance due): $15; Late Fee (after 60 days of balance due): $30. The practice reserves the right to send any individual to collections for failure to meet financial responsibilities.

Court Fees: $300/hour for non-expert testimony and $500/hour for expert testimony.

Copies of Records: Medical records exceeding 30 pages will be charged $.50 per page.

Forms: Disability and legal paperwork will be billed at 15-minute increments at the clinician's hourly rate.

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Additional Communication: If other services, such as telephone conversations, email exchange, or preparation of documents, take an unusual amount of time, there may be a charge.

Cancellation and No-Show Policy: I agree to notify the practice 24 hours in advance, or on Friday for a Monday appointment for any cancellation or reschedule. Failure to provide 24 hours' notice of cancellation will result in the following:

- 1st time, No Charge
- 2nd time / final time, full charge

No show, No call: does not show to appointment or call and leave a voicemail:

- 1st time, full charge
- 2nd time / final time, full charge

Medicare / TriWest (Community Care), and Tricare Patients: You understand that Grandview Therapy and Consulting, LLC may not charge you for late cancellations, no show fees, or various other fees. However, you understand that the above guidelines still exist. This means after your **second incident** involving patient appointments or care you will be discharged from my practice and need to find alternative treatment. You will be notified by your provider, and a formal discharge letter will be emailed / mailed to you to communicate your services are being terminated.

Patient Name: _____ Date: _____

In requesting the medical records as a designated agent, in signing below, I attest to the continuing inability of the above patient to make or communicate health care decisions.

Signature of Patient or Legal Guardian: _____

Date: _____

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Demographic and Contact Information

Date of Appointment: _____

First and Last name: _____

Preferred name: _____

Address: _____

_____

_____

Email: _____

Cell Phone: _____ *May Dr. Neale leave a message?* □ Yes □ No

Home Phone: _____ *May Dr. Neale leave a message?* □ Yes □ No

Work Phone: _____ *May Dr. Neale leave a message?* □ Yes □ No

Which number is preferred to call first? _____

Birthdate: _____/ _____/ _____

Marital Status: _____

Referral Source: _____

Emergency Contact Information

** This person will be contacted in the event of a mental health emergency

Emergency contact name: _____

Relationship: _____

Emergency Contact phone: _____

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Credit Card of File Policy

In order to ensure timely payment and minimize delinquent and outstanding account balances, a credit card is required to be kept on file to receive services from Dr. Allison and Associates. Accounts that are 60 days or more overdue, without a formal payment plan in place, will have the card on file charged accordingly. If the card on file declines for any reason, the overdue balances may be forwarded to a collections agency.

Card Holder's Name: _____

Credit Card Number: _____

Expiration Date _____

Security Code: _____

Type of Card: _____

Billing Zip Code: _____

Card Holder's Phone: _____

Card Holder's Signature: _____ Date: _____

I understand that by signing above, I am authorizing Grandview Therapy and Consulting to charge my card for balances outstanding for 60 days or more. These balances may include co-pays, co-insurance amounts, deductibles, no- show fees, late cancellation fees, payment plan agreements, and other accrued fees. Grandview Therapy and Consulting will contact me if my card is declined or expired. If a new card is not provided and payment is not received, non- emergent services may be suspended. Credit card information is securely stored with Grandview Therapy and Consulting's Practice Management Services.

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Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, have received a copy of the Notice of Privacy Practices for Grandview Therapy and Consulting, LLC.

Patient Name: _____

Signature of Patient or Legal Guardian: _____

Date: _____

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Patient Health Questionnaire (PHQ)

Over the last 2 weeks, how often have you been bothered by any of the following problems?

		Not at all	Several Days	More than half the days	Nearly every day
1.	Little interest or pleasure in doing things.	○	○	○	○
2.	Feeling down, depressed or helpless.	○	○	○	○
3.	Trouble falling or staying asleep, or sleeping too much.	○	○	○	○
4.	Feeling tired or having little energy.	○	○	○	○
5.	Poor appetite or overeating.	○	○	○	○
6.	Feeling bad about yourself—or that you are a failure or have let yourself or your family down.	○	○	○	○
7.	Trouble concentrating on things, such as reading the newspaper or watching television.	○	○	○	○
8.	Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual.	○	○	○	○
9.	Thoughts that you would be better off dead, or of hurting yourself in some way.	○	○	○	○

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Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several Days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge.	0	1	2	3
2. Not being able to stop or control worrying.	0	1	2	3
3. Worrying too much about different things.	0	1	2	3
4. Trouble relaxing.	0	1	2	3
5. Being so restless that it's hard to sit still.	0	1	2	3
6. Becoming easily annoyed or irritable.	0	1	2	3
7. Feeling afraid as if something awful might happen.	0	1	2	3
Add the score for each column	+	+	+	
Total Score (*add your column scores*) =				

If you checked off any problems, how difficult have these made if for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____

Somewhat difficult _____

Very difficult _____

Extremely difficult _____