Kathleen M. Albert, Ph.D

Complete Care Counseling, LLC
65 Middle Street
Manchester, NH 03101
603.622.7959

Informed Consent and Authorization to Release Information
Please INITIAL THE BLANKS if you agree to each statement

___I authorize Kathleen Albert, Ph.D. to provide therapeutic treatment for myself or my child. I understand that a parent of a minor child has the authority over the medical records and that at age 18 the child gains control of the file and the therapy process.

____Unless other arrangements are made payment is expected at the time of service. If arrangements are made for direct reimbursement from an insurance company, any co-payment or deductible is due at the time of service. I understand that while Complete Care Counseling, LLC will submit claims to my insurance company as well as assist in obtaining precertification as a service to me, I am ultimately responsible for the precertification and FULL payment of the services rendered if my insurance company denies the claim. I also understand that I might incur a late charge on outstanding balances.

_____I understand that charges will be submitted to my health insurance in accordance with the provisions of my policy.

____I assign payments to this office from my insurer for services to me or my dependents.

____I authorize disclosure by Complete Care Counseling of any and all records regarding _____to my health insurance representatives if such disclosure is necessary for claims proceedings, case management, coordination of treatment, or utilization review purposes.

____I understand that if I chose to utilize my insurance benefits, I must meet the criteria for a mental health disorder, and be given a mental health diagnosis by my provider. I realize that once this diagnosis is given to my insurance company, it then becomes a permanent part of my medical record, and may have an effect on life and health insurance premiums.

____I choose to waive my right to use my insurance for a service and pay privately. I agree to pay $_____ for the service of_____.

____I am requesting psychological and/or neuropsychological testing. I understand that I am financially responsible for any remaining balance related to this service after my

provider has fulfilled all contractual requirements with the insurer and exhausted all authorized benefits. This remaining balance may include deductibles, report writing, co-pays for authorized sessions, and the billed cost for service hours either beyond or not covered by limits of insurance coverage. The provider will proved an estimate of these additional costs, if any before the assessment has begun.

____I understand that I am responsible for any non-covered services rendered to me or my dependent(s). I understand that the fee for services is $130.00 per hour and fees for consultations or collateral contacts face-to-face, by telephone or in writing will be assessed by the 15 minute unit. In addition, all services provided outside this office (such as, School meetings and observations) are also billed directly to me. For these circumstances, time is rounded up to the nearest quarter hour and billed at an hourly rate of $130.00. If travel is required, I will be billed at $130.00 per hour of travel for round-trip travel time from this office to the place of service.

____If an insurance company has not paid outstanding charges within 90 days of the date of service, these charges will be billed directly to me. It is my responsibility to be sure that coverage is in effect, to see that any deductibles and/or co-payments are paid and to notify this office of any changes in insurance coverage. You will be billed for any charges which are not paid by your insurance company and which were not paid at the time of service. Insurance companies will not cover missed appointments and telephone consultations; these are your responsibility.

____ Patient accounts that are 90 days or more overdue are sent to collection. This may result in some loss of privacy as the collection agency may list the debt on the patient or responsible party's credit report. In addition to the overdue amount, collection agency commissions and/or legal fees incurred in the collection process will be added to the account balance. Currently, for 90-day balances, a 35% commission rate is applied; older balances are assessed a 50% commission rate. As a rule, treatment is suspended until satisfactory arrangements are made for payment.

____I understand that if I must cancel a scheduled appointment, 24-hour notice is necessary to avoid full charges ($130).

____ Unlike some agencies that offer comprehensive emergency services, I do not provide 24-hour service. If you feel that you are in crisis and are unable to reach me at the office, you can reach me (or another psychologist who may be covering for me in my absence) by calling the emergency numbers given on the office answering machine. If my provider is unavailable (such as, during weekend or evening hours) and you or a family member feels that there is an emergency or impending crisis, go to the nearest hospital's emergency room for assistance.

____Confidentiality of records or information collected will be held or released in accordance with state laws regarding confidentiality of such records and information.

____ I understand that in some legal proceedings, upon a court order, testimony and/or records may be rendered. I understand that if legal actions are brought against my clinician by the patient and/or family, information may be disclosed if necessary and relevant to the case. I understand that there may be other circumstances in which the law requires a clinician to disclose confidential information.

____I understand that state and local laws require that my provider report all cases of abuse or neglect of minors or the elderly and that state and local laws require that my therapist report all cases in which there exists a danger to self or others.

____Your provider may occasionally find it helpful to consult about cases with other professionals. During these consultations your provider will make every effort to avoid revealing your true identity. A consultant is legally bound to keep information confidential as well. Unless you object, I will not tell you about these consultations unless I feel it is important to our work together.

____For parents, you have the legal right (privilege) to your child's treatment records until your child turns 18 years old. However, for your child/adolescent to get the maximum benefit from therapy, you should respect his/her confidentiality (i.e.., he/she should be able to discuss things openly with the provider without parental intervention). I will provide the parents with general information about the child's progresses in therapy and in situations of high risk (such as, harm to self). It is important to include the parents in treatment to the fullest degree without interfering with the minor's progress.

____I give permission for Complete Care Counseling to leave telephone messages at home regarding appointments.

____I give permission for Complete Care Counseling to leave telephone messages at work regarding appointments.

____I understand that some phone calls may be returned to me by cell phone, which is limited in its confidentiality, and I authorize permission for these calls.

____I understand that I may revoke my consent at any time except to the extent that services have already been rendered or that action has been taken in reliance on this consent. This consent it will not expire automatically.

____I have read and understand the above.

_____ _____
Signature of adult client or guardian Date

_____ _____
Signature of assent by minor Date