

CAPC, LLC
Informed Consent and Assent for Assessment and Treatment

- I, and/or members of my family will be receiving services at Child and Adolescent Psychiatry Consulting, LLC (CAPC)
1. The type and extent of services that I will receive will be determined following an initial assessment and thorough discussion with me.
 2. The goal of the assessment process is to determine the best course of treatment for me. Typically treatment is provided over the course of several months to years.
 3. I understand that all information shared with the clinician is confidential and no information will be released without my consent. In the event that my clinician needs to speak with other providers or persons about my/my family member's care, consent to release information is given through written authorization. Verbal consent for limited release of information may be necessary in special circumstances. I further understand that there are specific and limited exceptions to this confidentiality which include the following:
 - A. When there is risk of imminent danger to myself or to another person, the clinician is ethically bound to take necessary steps to prevent such danger.
 - B. When there is suspicion that a child or elder is being sexually or physically abused or is at risk of such abuse, the clinician is legally required to take steps to protect the child, and to inform the proper authorities.
 - C. When a valid court order is issued for medical records, the clinician and the agency are bound by law to comply with such requests.
 4. I understand that while psychotherapy and/or medication, may provide significant benefits, it may also pose risks. Psychotherapy may elicit uncomfortable thoughts and feelings, or may lead to the recall of troubling memories. Medications may have unwanted side effects.
 5. If I have any questions regarding this consent form or my care with Dr Jenna, I may discuss them her. I have read and understand the above.
 6. I consent to participate in the evaluation and treatment offered to me by CAPC, LLC. I understand that I may stop treatment at any time.

Patient Signature(if over 14yo) _____ Parent/Guardian Signature _____

CAPC Fee Schedule

Initial Assessment: \$385
Therapy and med mgmt (45 min) \$280
Therapy and med mgmt (20 min) \$165
Telephone and other technological consultation (per 6-12 min) \$40.00
Reports/Letters/Consultation \$200/hr billed in 15 min increments
Forensic/Court-related work \$250/hr billed in 15 min increments
Crisis intervention(weekends/afterhours) \$200/hr billed in 15 min increments
Missed Appointment/cancel < 24hrs \$ 80
Cancellation Policy: No shows and failure to give 24 hr notice of cancellation will result in the no show charge. Failure to come to 3 appointments will result in discharge from clinic.

In the event that CAPC, LLC has no contract with your insurance carrier, you will be billed directly for payment of services. You will need to submit your invoice to your insurance company to request reimbursement from them to you. Typically, the reimbursement that you will receive is less than if you went to an in-network provider. To determine what the cost differential will be, you will need to contact your insurance carrier.

Many insurances do not cover services that do are not face to face clinical care.

ACKNOWLEDGEMENTS:

I have reviewed:

the GUIDELINES FOR PRACTICE for CAPC, LLC (initial here) _____

the NOTICE OF PRIVACY PRACTICES for CAPC, LLC (initial here) _____

the CAPC FEE SCHEDULE, including the cancellation and no-show policy.(initial here)_____

I understand that I may be billed directly for phone consultation, and other communications.(initial here) _____

I consent to release of information to my insurance for the purpose of billing:

Signature of responsible party:_____ Date: _____

PLEASE FAX COMPLETED FORMS AND A COPY OF YOUR INSURANCE CARD TO **888-485-4412**

CAPC, LLC
PATIENT DEMOGRAPHICS AND INSURANCE INFORMATION WORKSHEET

Patient Name: _____ Date of Birth: _____

Social Security Number: _____ Guardian: _____

Mailing Address: _____

Referred by: _____

Concerns: _____

Primary Insurance Information:

Info about the insured: (if not patient)

Name: _____ Birthdate: _____ SS #: _____

Address of Insured _____

Phone # _____ Employer _____

Insurance Company Name: _____ Effective Date: _____

Policy # _____ Group # _____

Insurance phone # _____ Insurance _____

In Network? (circle one) Yes No Out of Network Benefits? _____

Co-pay: _____

Secondary Insurance Information

Info about the insured: (if not patient)

Name: _____ Birthdate: _____ SS #: _____

Address of Insured _____

Phone # _____ Employer _____

Insurance Company Name: _____ Effective Date: _____

Policy # _____ Group # _____

Insurance phone # _____ Insurance _____

In Network? (circle one) Yes No Out of Network Benefits? _____

PLEASE FAX COMPLETED FORMS AND A COPY OF YOUR INSURANCE CARD TO **888-485-4412**