

Desired Outcomes

8050 Beckett Center Dr. 314

West Chester, OH 45069

Consent for Treatment

I agree and consent to participate in mental health counseling offered and provided by/at Kimberley Pollock, LPCC (Desired Outcomes). I understand that I am consenting and agreeing only to those services that the above named provider is qualified to provide within: 1) the scope of the provider's license, certification, and training. I also understand that while the course of my treatment is designed to be helpful, my provider can make no guarantees about the outcome of my treatment. Further, the psychotherapeutic process can bring up uncomfortable feelings and reactions such as anxiety, sadness and anger. I understand that this is a normal response to working through unresolved life experiences and that these reactions will be worked on between my provider and me. I understand that there may be risks and benefits of the proposed treatment, of alternative treatments, and of no treatment, which I can further discuss with my provider. I understand that I may refuse treatment at any time. I understand that efforts will be made to ensure that I receive needed services, including referral to a more appropriate provider if I need a specialist. I take full responsibility that if I refuse or terminate treatment, it could be detrimental to my mental health.

Patient/Guardian Agreement (indicate your choice)

_____ Desired Outcomes to submit insurance on my behalf _____ File EAP billing for me

_____ Client to self-pay

I authorize Kimberley Pollock, LPCC to release medical information necessary to process my claim for insurance, pre-certification, case management, quality improvement, utilization review, benefit administration and other purposes related to my health plan. I also authorize payment of medical benefits to be sent to Kimberley Pollock, LPCC for services described on the HCFA-1500 form. If at any time during treatment I become ineligible for insurance coverage, the provider will be notified and I will be responsible for 100% of the balance due on my account. Additional fees are charged for court requests, letters, reports and special services. Often these fees are not reimbursed by my insurance and payment is required prior to the delivery of final reports and letter requests. Insurance companies will not cover late cancellations or no shows. I have been notified of my responsibility for cancellation-no-show policy/fees. Any returned checks will result in a \$35.00 charge to my account plus the returned check amount.

Payment Responsibility

I understand that I am responsible for payment of all fees charged. I agree to pay for all services rendered, unless my insurance carrier (if I have one) pays for some or all charges. If I have insurance, I agree to make the co-payment for services rendered at the time of each visit. I understand that Desired Outcomes will submit any insurance claims for me, including those with or without a co-payment arrangement. I understand that if my insurance company denies payment, does not reimburse Desired Outcomes within 60 days for services rendered, or reimburses Desired Outcomes differently than they initially indicated, I will be personally responsible for payment, subject to interest of 2% per month on any unpaid balance.

I understand that if I miss any appointments, including the first one, I will automatically be charged for the full fee of the appointment. I understand insurance won't cover this charge. I understand if any of my checks are returned by the bank for non-payment, that amount plus a \$35 service charge will automatically be billed to me.

I hereby authorize Desired Outcomes to charge me as outlined herein.

By signing below, I certify that I have read and understand this agreement and have full knowledge of its meaning and effect and agree to my financial responsibilities.

Print Name: _____

Client Signature: _____

Date: _____