

Jackson County Psychological Services (JCPS)
Serving Western North Carolina
Consent for Services

Client Name _____

Record Number _____

CONSENT FOR SERVICES: I consent to services from JCPS, or I consent to the above Child/Youth to receive services, evaluations, or counseling. I agree to pay the fees assessed at the time of services. If, I or the individual named above, need emergency medical care while receiving services I give permission for JCPS to obtain such care, and I agree to be financially responsible for the services. I also understand that there are potential risks, benefits, and alternatives to treatment services. I understand I have the right to a copy of my service plan. Furthermore, when clinically indicated, I consent to being referred for an evaluation or having my child or ward evaluated by a physician or appropriately licensed health practitioner, for the purpose of determining whether psychotropic medication would be therapeutically beneficial. This consent shall be valid for one year or until services are terminated or if I wish to withdraw from services at JCPS.

RELEASE OF INFORMATION: I authorize JCPS and the Local Management Entity (Smoky Mountain Center) to release information as necessary for the purpose of filing for insurance compensation or for requisition compensation from Federal or State resources that may provide payment for services I receive including the release of information relating to the diagnosis and/or treatment of alcohol or substance abuse as protected by Federal Substance Abuse Confidentiality Regulations (CFR 42, part 2), and documentation of psychiatric care and/or psychological assessment, and information regarding human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS) or AIDS-related conditions as protected under the Health Insurance portability and Accountability Act of 1996 ("HIPAA"), 45 CFR, part 16 & 164. I further authorize the release of information to utilization review by organizations or agencies that provide managed care services for my insurance benefits.

DIRECT ASSIGNMENT OF INSURANCE PAYMENT: When JCPS and the Local Management Entity (SMC) files for third party insurance payment under my policy benefits, and they are otherwise payable to me as the policy holder, I authorize them to be paid directly to JCPS and the Local Management Entity (SMC.) If my policy prohibits direct payment to a doctor or treatment facility, the payment should be made to me or the policy holder and the payment should be further reimbursed to JCPS. This is a direct assignment of rights and benefits under my insurance policy. Payment will not exceed my indebtedness to JCPS.

I have read and understand all of the above, and I freely consent and agree to all the foregoing conditions and information. I understand that this consent will remain in effect for the duration of treatment, and that I can revoke this consent at any time except to the extent that services have already been provided. My signature below also acknowledges receipt and understanding of the client orientation booklet and gives my permission for my case manager to advocate on my/my child's behalf by sharing feedback regarding the services I/my child may receive from other agencies and organizations. I also acknowledge that I have been given choices regarding available community resources and available therapist/staff.

SIGNATURE: _____ **DATE:** _____
Client, Parent or Legal Guardian signature

CHARGES FOR FAILURE TO ADHERE TO SCHEDULING / SERVICE DELIVERY POLICIES: There will be a charge for not attending a psychiatric appointment if you "**no show**" or **do not cancel at least two days before your appointment**. When you cancel or no-show we are charging you for only half the amount rather than the full amount. There are **no exceptions** to this policy. There may also be the same charge if we have to cancel your session due to your not attending an appointment with a counselor required before your next psychiatric appointment. All unpaid charges will come up as a Health Services charge under your university student account.

- **There will be a \$100 charge for not attending the initial forty-five minute session**
- **There will be a \$45 charge for not attending a 15 min. medication follow-up session**

Student ID#: _____ Date of Birth: _____

Local Address: _____

Phone number where you would prefer the Health or Counseling Services to contact you: _____

Preferred email for contact: _____

I have read the above information pertaining to limitations of Psychiatric Services and agree to follow these guidelines.

Printed Name **Signature** **Date**