SUMMIT PSYCHOLOGICAL SERVICES
1350 Old Freeport Road, Suite 1A
Pittsburgh PA 15238
Phone: 412-406-7734 Fax: 412-406-7742

Consent Forms for Services with Summit Psychological Services

Please carefully review the following documents and sign each page to indicate you have received and understand them.

1. Informed Consent
2. Consent for Psychological Treatment and Release of Information to Insuring Party
3. Email Consent
4. Telehealth Consent
5. Authorization to Disclose Information to Primary Care Physician
6. Consent to Release Confidential Information to Family and or Significant Others for Mental Health Only
7. Financial Agreement
8. Credit Card Authorization Form
9. Acknowledgment of Payment Responsibility & Authorization to Charge Credit Card:

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Informed Consent

(Mandatory Signature)

Patient Name: _____ D.O.B.:_____

I or my child have/has voluntarily participated in an evaluation at Summit Psychological Services Outpatient Treatment. I understand that the diagnosis and the extent of any specific problems will be adequately explained to me. Also, I understand I will be informed of the risks and benefits of any proposed treatment, the risks and benefits of alternative treatments, and the likely effect of no treatment.

I understand the following statements:

- Pennsylvania law regarding the mandatory reporting of child abuse. This has resulted in some important updates to the limits of confidentiality. All providers at Summit Psychological Services may be required by Pennsylvania Law (Act 31, 2014) to report if they have any reason to suspect, based on their professional judgment, that a child is being or has been abused. They are required to report any suspicion to the authority or government agency vested to conduct child abuse investigations. They are mandated to report suspected child abuse if anyone aged 14 or older tells them that he or she committed child abuse, even if the victim is no longer in danger. They are also mandated to report suspected child abuse if anyone tells them that he or she knows of any child who is being abused.
- I will refrain from any action or omission designed to deceive or manipulate any healthcare professional into prescribing medications or providing duplicate services.
- My financial obligations about the recommended treatment have been fully explained to me.

I have read the above information and understand what treatment services will be provided and I voluntarily consent to receive the recommended treatment.

_____ _____

Patient (14 years and older) - or - Parent/ Legal Guardian Date

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Consent for Psychological Treatment and Release of Information to Insuring Party

(Mandatory Signature)

Patient Name: _____ D.O.B.: _____

By signing this form, I hereby voluntarily consent to treatment through Summit Psychological Services, and further authorize said organization, as holder of medical or other information about me, to release information as needed to the insurance carrier(s) responsible for payment of services rendered. The information that I hereby authorize for release with this form is limited to the information that is necessary for the processing of the claim by the insurance carrier(s) for payment for professional services being provided by Summit Psychological Services.

I hereby acknowledge and authorize that a copy of this consent for treatment and release of information will serve as an original for all purposes stated in this document.

I hereby request and authorize the payment and assignment of benefits for treatment provided by and through Summit Psychological Services, to the same, *regulations pertaining to the assignment of medical benefits notwithstanding*.

_____ _____

Patient (14 years and older) - or - Parent/ Legal Guardian Date

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E-Mail Consent Form

(Optional)

Patient Name: _____ D.O.B.:_____

Patient E-mail Address: _____

1. RISK OF USING E-MAIL

Summit Psychological Services offers patients the opportunity to communicate by e-mail. Transmitting patient information by e-mail, however, has several risks that patients should consider before using e-mail. These include, but are not limited to, the following risks:

a. E-mail can be circulated, forwarded, and stored in numerous paper and electronic files.
b. E-mail can be immediately broadcast worldwide and be received by many intended and unintended recipients.
c. E-mail senders can easily misaddress an e-mail.
d. E-mail is easier to falsify than handwritten or signed documents.
e. Backup copies of e-mail may exist even after the sender or the recipient has deleted his or her copy.
f. Employers and on-line services have a right to archive and inspect e-mails transmitted through their systems.
g. E-mail can be intercepted, altered, forwarded, or used without authorization or detection.
h. E-mail can be used to introduce viruses into computer systems.
i. E-mail can be used as evidence in court.

2. CONDITIONS FOR THE USE OF E-MAIL

Summit Psychological Services Providers will use reasonable means to protect the security and confidentiality of e-mail information sent and received. However, because of the risks outlined above, Providers cannot guarantee the security and confidentiality of e-mail communication and will not be liable for improper disclosure of confidential information that is not caused by Provider's intentional misconduct. Thus, patients must consent to the use of e-mail for patient information. Consent to the use of e-mail includes agreement with the following conditions:

a. Because e-mails are considered a part of the medical record, other individuals authorized to access the medical records, such as staff and billing personnel, will have access to those e-mails.
b. Provider may forward e-mails internally to Provider's staff and agents as necessary for diagnosis, treatment, reimbursement, and other handling. Provider will not, however, forward e-mails to independent third parties without the patient's prior written consent, except as authorized or required by law.
c. Although Provider will endeavor to read and respond promptly to an e-mail from the patient, Provider cannot guarantee that any e-mail will be read and responded to within any particular period. Thus, the patient shall not use e-mail for medical emergencies or other time-sensitive matters.
d. If the patient's e-mail requires or invites a response from the Provider, and the patient has not received a response within a reasonable time, it is the patient's responsibility to follow up to determine whether the intended recipient received the e-mail and when the recipient will respond.
e. The patient should not use e-mail for communication regarding sensitive medical information, such as information regarding sexually transmitted diseases, AIDS/HIV, developmental disability, or substance abuse.
f. The patient is responsible for informing Provider of any types of information the patient does not want to be sent by e-mail, in addition to those set out in 2(e) above.
g. The patient is responsible for protecting his/her password or other means of access to e-mail. Provider is not liable for breaches of confidentiality caused by the patient or any third party.
h. Provider shall not engage in e-mail communication that is unlawful, such as unlawfully practicing medicine across state lines.
i. It is the patient's responsibility to follow up and/or schedule an appointment if warranted.

3. PATIENT ACKNOWLEDGMENT AND AGREEMENT

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of e-mail between Provider and me, and consent to the conditions outlined herein. In addition, I agree to the instructions outlined herein, as well as any other instructions that Provider may impose to communicate with patients by e-mail. Any questions I may have had were answered.

_____ _____

Patient/Parent or Legal Guardian Signature Date

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Informed Consent to Telehealth Services

This form describes Summit Psychological Services Telehealth treatment and payment policies and includes:

- Your consent to receive treatment from Summit Psychological Services
- Your agreement to receive services using telehealth technology
- Your agreement to pay in full any charges that are your responsibility.

I understand and agree that:

- By using the Kareo's patient portal and virtual telehealth link, I agree to receive telehealth services.
- Telehealth involves the delivery of health care services, including assessment, treatment, diagnosis, and education, using interactive audio, video, and data communications. During my visit, my Summit provider and I will be able to see and speak with each other from remote locations.
- I will not be in the same location or room as my medical provider.
- My provider is licensed in the state in which I am receiving services. I will report my location accurately during registration.
- Potential benefits of telehealth (which are not guaranteed or assured) include:
    - Access to medical care if I am unable to travel to my provider's office
    - More efficient medical evaluation and management
    - During the COVID-19 pandemic, reduced exposure to patients, medical staff, and other individuals at a physical location.
- Potential risks of telehealth include:
    - Delays in evaluation and treatment due to technical difficulties or interruptions, distortion of diagnostic images or specimens resulting from electronic transmission issues.
    - Unauthorized access to my information, or loss of information due to technical failures.
- I will not hold Summit Psychological Services responsible for lost information due to technological failures.
- I may discuss these risks and benefits with my provider and will be given an opportunity to ask questions about telehealth services. I have the right to withdraw this consent to telehealth services or end the telehealth session at any time without affecting my right to future treatment by Summit Psychological Services.
- I understand that the level of care provided by my Summit Psychological Services provider is to be the same level of care that is available to me through an in-person medical visit. However, if my provider believes I would be better served by face-to-face services or another form of care, I will be required to attend appointments in person.
- I have the right to receive face-to-face medical services at any time by traveling to a Summit Psychological Services location that is convenient to me.
- In case of an emergency, I will dial 911 or go directly to the nearest hospital emergency room

Telehealth Payment Policy

I acknowledge, understand, and agree that:

- It is my responsibility to determine whether the telehealth services rendered at Summit Psychological Services are covered by my insurer.
- I will pay the cost of any service that is not covered by my health plan for any reason or are covered but applied to a deductible.
- I will pay at time of service any required co-payments, co-insurance, and deductibles, as well as charges for services not covered by insurance, outstanding balances, and delinquent accounts.
- Non-emergent services may be cancelled for non-payment.

My signature below verifies that I have read and understand the above information about consenting to telehealth services at Summit Psychological Services:

Patient Name: _____ Date of Birth: _____

_____

Signature ***Date***

If I am signing on behalf of a minor, incapacitated or otherwise legally dependent patient, I certify that I am a person with legal authority to act on behalf of the patient, including the authority to consent to medical services, and I accept financial responsibility for services rendered.

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Authorization to Disclose Information to Primary Care Physician

(Mandatory Signature)

Patient Name: _____ D.O.B.: _____

I understand that my records are protected under the applicable state law governing health care information that relates to mental health services and under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records 42 CRF Part 2 and cannot be disclosed without written consent unless otherwise provided for in state or federal regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. This release will automatically expire twelve months from the date signed.

I, _____, hereby authorize Summit Psychological Services
(Please print patient's name)

Please check one:

☐ **To exchange any applicable information with my Primary Care Physician**

☐ **Not to release information to my Primary Care Physician**

_____ _____
Patient (14 years and older) - or - Parent/ Legal Guardian Date

Primary Care Physician's Name, Address & Phone:

_____

_____

_____

_____

Note to Behavioral Health Care Provider:
Please maintain original copy in patient's file

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Consent to Release Confidential Information to Family and or Significant Others
For Mental Health Only

Patient Name: _____ DOB: _____

I hereby request and authorize Summit Psychological Services to verbally release information regarding myself to the individuals listed below. I understand that the purpose of this release is to provide communication between Summit Psychological Services and the person(s) listed below. This information exchange will provide an aid for my treatment and for my family's support.

I hereby request and authorize you to release the information below to the following individuals: (Specify person's name and relationship):

_____ _____

_____ _____

_____ _____

_____ _____

You have my permission to VERBALLY release the following information:

- ☐ Name of Therapist/Med Provider
- ☐ Scheduled Appointments
- ☐ Medications
- ☐ Treatment Plan Information
- ☐ Discharge Information / Plans
- ☐ Attendance

I understand that this gives my consent for the verbal release of information to the individual(s) listed above. I also understand that this allows the above-mentioned person(s) to provide information to my therapist or Medication Provider. This release will expire in one year from the below date unless otherwise revoked. I understand that information released under this authorization may be re-disclosed by the receiving party, and therefore Summit Psychological Services and its employees have no responsibility or liability because of any re-disclosure; as such, the released information is no longer protected by the Privacy Rule.

_____ _____
Patient or Parent/ Legal Guardian Signature Date

*_____ Verbal authorization given by patient. Patient physically unable to give written consent.

_____ _____
Staff Signature for Verbal Auth Witness for Verbal Auth

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-Financial Agreement-

PATIENT NAME: _____BIRTHDATE: _____

Patient Financial Responsibilities:

The patient (or patient's parent/guardian, if a minor) is ultimately responsible for the payment of treatment and care. We will bill your insurance for you as a courtesy. Please note:

- The patient portion of fees is required at the time of service and is non-negotiable. This includes copays, coinsurance, deductibles, and any treatment cost not covered by their insurance plan. **Initial**: _____

- Patients are responsible for knowing about their insurance coverage and benefits. Your insurance is a contract between you, your employer and the insurance company. All charges are your responsibility from the date the services are rendered. **Initial**: _____

- If you have a managed care insurance plan, it is your responsibility to call for initial/prior authorization, if required by your plan, before the first appointment. You will be responsible for any charges that your plan refuses to cover. **Initial**: _____

- As a courtesy, Summit will inform you of your co-pays, co-insurance or deductible as per our third-party billing company. However, Summit Psychological Services, recommends that you contact your insurance company by calling the number listed on the back of your insurance card and inquire about your mental health benefits or what portion of any relevant deductible that needs to be met.

- Please be aware that many insurance plans now have high deductibles amounts. Until it is established that you have met your mental health deductible for the year, you are required to pay in full, in advance, for each visit. Any overpayment on your part will be refunded.

- The patient is required to provide the most correct and updated information regarding insurance and credit card on file. **Initial:** _____

- Patient acknowledges that not all issues, conditions, and problems dealt with in psychotherapy are reimbursed by insurance companies. **Initial**: _____

- Patient will discuss any change in his/her/their financial situation. In the event you find it necessary to change mental health providers and require records to be sent by Summit Psychological Services to your new provider, ***your account will need to be paid in full***. **Initial**: _____

- Minor children – for purposes of billing services, minor children are those individuals who are 18 years old, and still in high school, or younger.

    - Services not covered by insurance for minor children will be billed to the parent(s) with whom the child resides.
    - The responsibility for payment of services of minor children whose parents are divorced rests with both parents, unless directed by a court order.

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- Financial responsibility as stipulated by a court-order must be determined between the parties involved, but not by or with Summit Psychological Services.

Both Parents (if applicable): **Initial:** _____ **Initial:** _____

- Patients may incur, and are responsible for payment of additional charges, if applicable. **Initial**: _____

Non-Covered Charges

- Workman's comp claims: We require payment upfront by the patient or payment from an insurance company which can be turned into workman's comp after your visit.
- If we do not participate with your insurance company, payment is due at the time of your visit.
- If you have major medical coverage, we will provide you with any clinical information you need to fill out and submit your own insurance claim form. However, payment in full is due at the time of your visit.
- Once your insurance company has paid its portion of the charges, you are responsible for any remaining balance.

ADDITIONAL FEES**:

- Forms Completion - $10-$75 depending on the complexity of the form.
- Letters and Reports – Determined on a case-by-case basis.
- Non-sufficient funds (bounced) check - $35.00 per incident
- Mailed Samples - $5.00 plus postage.
- Late cancelations/Missed Appointments – fewer than 24 hrs. prior to appointment $50.00

CREDIT CARD ON FILE:

- Upon scheduling your first appointment you will be asked to provide credit card information which will be kept on file to be used as a form of payment for fees incurred for co-pays, co-insurance, deductibles, late cancelations, missed appointments, returned checks, or past due account balances.
- Your credit card information is encrypted and stored in a manner that is inaccessible to any of our staff or other party at Merchant Services of stripe.com with whom Summit Psychological Services has an account.
- You will also be asked to execute a Credit Card Authorization which authorizes Summit Psychological Services to charge my credit card for services rendered, if my account becomes delinquent or if my check is returned from the bank.
- A receipt will be e-mailed to you at the address you specify below or by the U.S. Postal Service if requested by patient in writing.
- In the event you refuse to have a credit card placed on file and authorize Summit Psychological Services to charge that credit card for any and all amounts not covered by the patient's insurer, PLEASE BE ADVISED THAT IN THE EVENT THERE ARE OUTSTANDING BALANCES, WE MAY REFUSE TO TREAT AND/OR SEE YOU AND/OR PROVIDE YOU WITH MEDICAL CARE unless such refusal is

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- otherwise prohibited by State and/or Federal law and/or the provisions set forth in any applicable insurance policy and or contract.

PRIVATE/SELF-PAYMENT FOR SERVICES

In some circumstances, patients do not wish to have their claims submitted to insurance carriers or do not have an insurance carrier. Patients do have the option to self-pay for services at Summit Psychological Services. The Self-Pay fee schedule is presented below.

Self-Pay Rates**				
	Below rates show original rate / 30% self-pay discounted rate)			
	Psychiatrist	CRNP	Psychologist	Therapist
90791	NA	NA	$200 / $140	$175 / $122.50
90832	NA	NA	$90 / $63	$50 / $35
90834	NA	NA	$150 / $105	$125 / $87.50
90792	$300 / $210	$250 / $175	NA	NA
99213	$130 / $91	$125/ $87.50	NA	NA
99215	$200 / $140	$175 / $122.50	NA	NA
99212	$90 / $63	NA	NA	NA
Psychological Testing Eval	NA	NA	$150	NA
Psychological Testing	NA	NA	$600	NA
Missed Appointments	$50	$50	$50	$50

****ALL FEES WITHIN THIS AGREEMENT ARE SUBJECT TO CHANGE**

ACCOUNT BALANCES:

Patients who have questions about their bills or who would like to discuss a payment plan option may call and ask to speak with the billing coordinator or office manager who will review your account and concerns. Patients with balances exceeding $150.00 **must** make payment arrangements prior to future appointments being made. If patient has not made a good faith effort to make payments as agreed or required by your contract with your insurance company, ***Summit Psychological Services may discontinue services until your account is current.***

If your account has not been paid for more than 60 – 120 days from your statement date and arrangements for payment have not been agreed upon, Summit Psychological Services reserves the right to resort to legal means to secure payment. This may involve hiring a collection agency, an attorney or going through small claims court. If such legal action is necessary, you will be responsible for those costs.

Please Note: Collection proceedings may result in legal action and may permanently damage your credit.

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Acceptable forms of payment: Cash, check, or credit card

- All checks should be made out to "Summit Psychological Services".
- Please review the **Credit Card Authorization Policy**, initial and sign where indicated.
- Please complete the **Credit Card Authorization Form** to provide the credit card information you would like to keep on file. If you have an FSA or HSA debit card, you can provide that information on the Credit Card Authorization Form in addition to your credit card information.

Desired method of payment please check one:

_____ I will pay each charge in full (self-pay).

-Or -

_____ I choose to have charges submitted to insurance and will pay amounts not paid by insurance at the time of service.

Initial below to indicate your understanding:

_____ If I have not paid w/in 60 days of my statement I understand I may not be able to schedule appointments and I will be sent to collections to obtain that payment.

Patient name (printed): _____

Patient /Parent or Guardian signature: _____

If Applicable-
Parent or Guardian name (printed): _____

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Credit Card Payment Authorization Form

Please sign and complete this form to authorize Summit Psychological Services to apply charges to your credit card as listed below.

By signing below you acknowledge that you have read Summit Psychological Services' financial agreement policy. I also understand if my card is declined and I have not made any payments towards my balance in 120 days, my account is considered inactive and may be sent to a credit collections agency. By signing this form, you give Summit Psychological Services permission and authorization for the following:

- Permission for my credit card to be charged automatically at the completion of each appointment with Summit Psychological Services for the copay or deductible amount dictated by my insurance company.
- Permission for my credit card to be charged for missed appointments and late cancellations/reschedules according to the policies and fees specified in the Summit Psychological Services' financial agreement.
- Upon the termination of services, I understand that my credit card will be charged any remaining balance owed unless special payment arrangements have been agreed upon.

I, _____, authorize Summit Psychological Services to charge my account for services rendered pursuant to the **Credit Card Authorization Policy** and **the Patient Financial Agreement**.

Credit Card Information

Cardholder Name (as it appears on the debit/credit card):

_____

Relationship to Patient: □ Self □ Parent □ Foster Parent □ Relative □ Other: _____

Type of Card: □Visa □ Mastercard □ Discover □ American Express

Card Number: _____

Expiration Date (MM/YY): _____

Security Code (CVV) - (last 3 numbers on back of Visa, Mastercard or Discover or 4-digit code on upper right side of American Express Card): _____

Billing Address: _____

City:_____

Zip Code:_____

Phone Number: _____

Email Address: _____

Signature:_____ Date: _____

I authorize the above-named business to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the behavioral health services provided by Summit Psychological Services. I certify that I am an authorized user of this credit card and that I will not dispute the payments with my credit card company so long as the transaction corresponds to the terms indicated in this form or the Financial Agreement I executed with the practice. I further authorize Summit Psychological Services to disclose information about my attendance/cancellation to my credit card issuer if I dispute a charge.

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Acknowledgment of Payment Responsibility & Authorization to Charge Credit Card:

I understand that the **Credit Card Authorization** agreement is meant to supplement and be consistent with **the New Patient Agreement** that I entered with Summit Psychological Services, as well as the **Patient Financial Agreement** that I executed.

INITIAL:_____

I understand that I am personally responsible for the payment of treatment and/or medical services and/or medical supplies, provided to me and/or my child/dependent by Summit Psychological Services.

INITIAL:_____

I further understand that the payments for which I may be personally responsible include, but are not limited to, co-payment(s), deductible(s) and/or any outstanding balances or fees that are not covered by my own and/or my child/dependent's health insurance policy.

INITIAL:_____

I understand that the card(s) kept on file must be current. If the payment method declines, additional fees may be incurred.

INITIAL:_____

I am personally responsible for the payment of my own and/or my dependent's medical care. I hereby willingly authorize Summit Psychological Services to charge my credit card for any and all medical services rendered to me and/or my dependent/child that are not covered by my own and/or my child/dependent's health insurance policy, including co-pays, deductibles, co-insurance, and late cancel/missed appointment fees, any additional fees as outlined in the Financial Agreement.

INITIAL:_____

I am aware that if my insurer pays Summit Psychological Services after my credit card has been charged, my credit card will be promptly reimbursed in the amount paid by my insurance company; in the alternative, if I so desire, I can request that Summit Psychological Services retain all or some part of that amount, as a credit on my account for my next visit. If I have any questions, I can contact Summit Psychological Services at summit@summit-psych.com.

I affirm that the statements contained herein are true to the best of my knowledge; that I am authorized to incur this charge to my credit card and hereby authorize future credit card charges necessary; to pay outstanding balance as stated above.

Patient Name:_____

Signature of Patient and/or Legal Guardian: _____

Date: _____

You will receive a copy of this credit card authorization via email OR if you wish it can be printed for you at our office.