OUTPATIENT MENTAL HEALTH PATIENT INFORMATION FORM
and
CONSENT FOR TREATMENT

Patient Name: _____ Ins. ID#: _____

It is our goal to assist you with the problems you are currently experiencing. It is important that you understand basic information about covered benefits for outpatient mental health services provided through your health plan. Please feel free to discuss your questions and/or concerns with your therapist. You may also contact our business office (215-914-2119 ext. 103) with any questions regarding your bill.

Your first session at Philmont Guidance Center will last 45-60 minutes and will consist of an initial interview with a clinician and may include self-assessment questionnaires. Paperwork will also need to be completed before this first session that will give us basic demographic and developmental information about the identified patient, emergency contact numbers and consent for treatment.

Follow-up therapy sessions are usually forty-five (45) minutes in duration. Group or family therapy sessions may be longer. Psychiatric consultations, regarding medication management are typically shorter sessions (10-15 minutes).

While we do our best to match your needs with the skill and personality of the therapist conducting the intake, you may feel that a change in therapist would be beneficial. Please feel free to speak to your therapist about this. You can also feel free to contact the office staff if you feel a change in therapist would be in your best interest.

Treatment fees for Mental Health Services:

Co-payments and deductible amounts are set by your insurance company and are not subject to negotiation with Philmont Guidance Center. Call your health plan or consult your member handbook for additional information.

Co-payments for services may change without notice. You are responsible for any additional co-payments due. You are responsible for informing the office about changes to your policy that may affect your coverage. Insurance companies do not allow us to retroactively bill for services rendered beyond certain time frames. *You will be responsible for full payment of fees if we are not informed in writing about changes to your insurance before services are rendered.*

Cancellations must be phoned in at least one business day in advance of your scheduled session. Cancellations for sessions with the psychiatrist must be done with one of the secretarial staff and *cannot be left as a voicemail*. A fee of $65.00 will be charged for each missed treatment session or late cancellation. A fee of $100.00 will be charged for missed psychiatric evaluations. There are no exceptions to this fee. In the event that your insurance plan does not allow us to charge you a no-show fee, Philmont Guidance Center reserves the right to immediately terminate our treatment relationship with you following any missed appointment. You will be notified of this in writing and will be given the names of other providers that may or may not be convenient for you, and may or may not take your insurance.

If a crisis or an emergency develops and you need to contact a clinician, pleased call the office where you are seen. We have a 24-hour a day, 7 day a week emergency answering service that will contact your therapist, or a covering clinician. You can reach the emergency service through our phone system options, or by calling them directly at 215-636-8726. There is no charge for emergency calls taken outside of the normal business hours. However, the therapists and psychiatrists who work at Philmont Guidance Center are independent contractors and reserve the right to charge for non-emergent phone calls or calls for medication refills outside of normal business hours.

With your consent, a brief summary of care is periodically sent to your primary care physician.

If you have additional questions and/or concerns, you may contact the company that manages your mental health care benefits directly. Their telephone number is usually on the back of your insurance card.

Continued

CONSENT FOR TREATMENT

By signing below, the patient or guardian agrees to the following financial conditions of treatment:

I consent to treatment by the staff of Philmont Guidance Center for myself, or my child.

I understand that I am obligated to pay co-payments and deductibles as required by my health insurance. I also understand that I will be financially responsible for all treatment fees if I fail to keep Philmont Guidance Center informed in writing of changes in my insurance.

I understand that all payments are due at the time of service. If Philmont Guidance Center sends a bill for services rendered, there will be an additional $25 fee charged. Any outstanding bill for services rendered will be turned over to collections if not paid promptly. I authorize my insurance benefits be paid directly to Philmont Guidance Center. I accept responsibility for payment for all non-covered services and I authorize the release of pertinent medical information to insurance carriers.

Treatment at Philmont Guidance Center will be suspended and I will be assumed to withdraw from treatment if I fail to keep my account up to date. Should my account be deemed delinquent, all future appointments will be cancelled.

I understand that any patient receiving medication from a psychiatrist at Philmont Guidance Center must see a therapist on a regular basis, approximately four times a year, unless otherwise authorized by the Medical Director. I understand that treatment at Philmont Guidance Center will be terminated if expected appointments with a therapist are not maintained.

I give permission for all persons acting on behalf of PGC to contact me and leave messages at the following address and phone number. To change this permission, I must contact PGC in writing:

Address: _____

_____

Phone: (H) _____ (C) _____

(W) _____

email: _____

☐ By checking this box, you are signing up to receive periodic news and information about Philmont Guidance Center that will be sent to the above email address.

I have read both pages of this document and understand the above information.

X_____ X_____
Patient Signature (14 and over) date

X_____ X_____
Parent/Legal Guardian Signature date
(for patients under age 18)