SHARED VISION
PSYCHOLOGICAL SERVICES
Building Healthy Connections

All-Inclusive Consent & Acknowledgment

Consent to Treatment:

You voluntarily agree to receive mental health assessment, care, treatment, and services and authorize Shared Vision Psychological Services, Inc. to provide such care, treatment, and services as are considered necessary and advisable. You understand and agree to participate in the planning of your care, treatment, and services, and that you may stop such care, treatment, and services at any time.

You further understand that SVPS upholds a commitment to professional training of doctoral and post-doctoral candidates and, should your assessment or treatment service be conducted by a clinician operating under the license and supervision of a Clinical Psychologist, this will be discussed with you prior to the initiation of care.

By signing this consent form, you, the undersigned client or parent/guardian, acknowledge that you understand all the terms and information contained herein. Ample opportunity has been offered to ask questions and seek clarification.

Your signature below grants consent to Shared Vision Psychological Services and the clinician coordinating your services to use and disclose your protected health information for the purposes of assessment, treatment, payment, and other healthcare operations. Your signature also provides consent for direct payment of medical benefits to Shared Vision Psychological Services, Inc. We encourage you to read this agreement in full before signing this consent.

If Applicable: By signing as a parent/guardian, you hereby give authorization and consent for the patient to receive outpatient assessment/treatment from Shared Vision Psychological Services. You understand it is the policy of SVPS that the parent/guardian bringing the patient is responsible for payment at the time services are rendered. You will be responsible for payment of the services rendered regardless of any financial arrangement for the payment of the patient's medical care, either oral or written, with the patient's other parent or responsible party. You understand that SVPS assumes no responsibility for collecting payment from the other parent or responsible party with whom I may have financial arrangements for the patient's medical care.

Telehealth Services Consent:

Throughout this time ahead, the use of electronic communication will afford us the ability to stay connected and continue to provide you and your family services. Major insurance companies are reporting that telehealth services will be covered the same as in-person visits.

Risks of phone and video sessions include: the reduction in nonverbal communication, possible service interruptions or technology challenges, and the need to find private space for your call or video session. Should your connection get interrupted during sessions, please email or call your clinician to re-connect or reschedule another appointment.

Telehealth Acknowledgements and Agreements:

I request that all communications and services from Shared Vision Psychological Services (SVPS) be delivered to me by the provided electronic means. I understand that this form of communication may not be secure, creating a potential risk of disclosure to unauthorized individuals. No method of communication is completely confidential. However, the standard for phone and video chat services is end-to-end encryption and saves only the meta-data (who was called and how long the call lasted). I understand and agree that the security and encryption of the requested communication cannot be completely guaranteed, making my PHI at risk for possible receipt or interception by unauthorized individuals. My signature below serves as acknowledgment of these risks and releases SVPS from any liability should any unintended disclosures occur. My signature also indicates that this agreement is valid until either party withdraws consent for electronic communications.

Consent for Contact:

I agree to have my name placed on a mailing list and an email list to receive follow-up contact from Shared Vision, including, but not limited to, newsletters, educational information, Clinic updates, etc. Shared Vision will not sell or provide mailing list(s) to any third party. I understand that I can revoke this consent at any time.

Acknowledgments:

By signing below, I acknowledge the following:

- I have been offered the Illinois Notice Form outlining privacy regulations relevant to my care.

- I authorize use and disclosure of my personal health information for the purposes of diagnosing or providing treatment to me, obtaining payment for my care, or for the purposes of conducting the behavioral health operations of Shared Vision Psychological Services. I authorize SVPS to release any information required in the process of applications for financial coverage for the services rendered. This authorization provides that SVPS may release objective clinical information related to my diagnosis and treatment that may be requested by my insurance company (if applicable) or its designated agent.

- I authorize and request my insurance plan (if applicable) pay directly to SVPS the amount due for services rendered to the patient, myself, or others covered by the insurance plan(s) under which I have registered. I authorize the release of any medical, mental health, or substance abuse information necessary to process insurance claims for services rendered. I

understand that this consent is subject to revocation at any time, except where action has already been taken on the basis of this release. Unless revoked earlier, this consent will be null and void six months after the final payment has been received on this account. This consent is subject to state and federal confidentiality regulation.

- I agree to take full responsibility for the entire amount due for any and all services rendered. If the provider is contracted with my insurance company, I will be responsible only for the co-pay, co-insurance, deductible, and non-covered services as determined by the insurance plan. If I do not inform SVPS in a timely manner of any changes to my insurance coverage, I understand that I many need to pay for services in full if payment is denied in part or in full by my insurance carrier. I further understand that I may not be able to schedule appointments if my account becomes delinquent and/or my account is turned over to collections.

- I agree to provide a credit card to have on file in order to process payments. I grant permission for the credit card account listed to be charged per SVPS policies.

- I understand that my patient records are the property of SVPS and shall be treated as confidential; that SVPS will conduct routine patient audits to insure quality record maintenance; that my records will not be released without my written consent or as provided by the Illinois law. I understand that if I choose to have my records or treatment updates provided to a third party, I must request this in writing using SVPS 'Authorization for the Release of Information' form or another acceptable form, with the exception of information I have agreed to release per this Acknowledgment.

- I acknowledge that if I need to cancel or reschedule an appointment, I will provide a minimum notice of one business day for therapy and two business days for evaluation sessions. Otherwise, I understand that I am subject to the full charge for the missed appointment and am responsible for payment in full.

- I acknowledge that SVPS is not a 24-hour crisis care facility and that I am responsible for seeking care at my nearest emergency room or through another provider of choice when my SVPS therapist is not available.

- I certify that all of the information I have provided is true and correct.