2441 Cabezon Blvd SE
Rio Rancho, NM 87124
505-717-1155

2112 Main Street NE
Los Lunas, NM 87031

Informed Consent – Families

We hereby request that

_____ (Patient Name & DOB)

_____ (Patient Name & DOB)

_____ (Patient Name & DOB)

_____ (Patient Name & DOB)

_____ (Patient Name & DOB)

_____ (Patient Name & DOB)

we be accepted for mental health treatment family counseling services as described to us.

1. We give our authorization and consent to receive outpatient diagnostic and treatment services from The Family Connection, LLC.
2. We have received and understand My Rights and Responsibilities as a Family Connection, LLC patient regarding treatment and agree to these statements.
3. We have been given the Notice of Privacy Practices of The Family Connection, LLC which describes how medical information about our information may be used and disclosed and how we can get access to this information.
4. We have been given The Family Connection's Social Media policy which describes how The Family Connection LLC and its employees conduct ourselves on the Internet as mental health professionals and how you can expect us to respond to various interactions that may occur between us on the Internet.
5. We have signed and understand the specific constraints of participating in couples/family counseling and are in agreement with its limitations.
6. We understand that confidentiality is extended to the entire unit, as the couple unit is the Identified Patient. We understand that records will not be released unless the entire unit consents as privilege for confidentiality is held by the unit, not individuals within the unit.
7. We understand that we have a right to have our information kept confidential. This information will remain confidential unless certain criteria are met; everyone in the family unit provides written consent to disclose specific information, if anyone in the family unit is in imminent danger to self or others or if anyone in the family unit discloses abuse (physical, sexual, etc. or neglect) that The Family Connection, LLC is required by law to report or if the court requires specific information.
8. We have read and understand the limitations of confidentiality in couples counseling as outlined in the Couple/Family Counseling Policy and are in agreement with the "no secrets" policy.
9. We acknowledge that The Family Connection LLC conducts on-going in-house training and that details of our case, without identification of the patient, may be discussed to improve treatment during clinical supervision.

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10. We have been given information regarding the cost of services from The Family Connection, LLC. We understand that we may be responsible to pay a co-pay and that it is payable each time I receive treatment and that it is our responsibility to work with our insurance company regarding disputes. We also acknowledge that we are responsible for any fees not covered by the insurance company.
11. We have signed and understand the specific constraints of participating in family counseling and are in agreement with its limitations.
12. We understand that we may address any concerns or grievances with my therapist or any other representative of The Family Connection, LLC at any time. We understand that we may also contact the licensing board which regulates my therapist's professional practice.
13. We are freely choosing to enter into treatment, and we understand that we may discontinue treatment at any time.
14. We have been given information about the advantages and disadvantages of the treatment recommended, as well as other alternatives. As with any effort to create lasting change, counseling requires time, energy and commitment. Counseling can feel frustrating because we cannot control the pace of change. On the path toward healing, clients may experience an increase in painful feelings; this is a normal part of the process.
15. We authorize the release of any medical or other information necessary to process claims. We also request payment of governmental benefits to The Family Connection, LLC. We recognize that we will bill under the insurance (as applicable) of the person the unit identifies in the referral as the person whom they chose to access their insurance benefits. We understand that all documentation will be under the identified insured person's name but confidentiality will remain as the entire unit. We authorize payment of medical benefits to The Family Connection, LLC for treatment services.
16. We understand that we may be assessed the full session fee for all/any appointment cancelled without 24 hour notice. We understand that, unless previously outlined by our therapist, all participants in the family counseling must be present to or the session may be cancelled and the full session fee assessed.
17. We understand that the role of the therapy is treatment and it is policy of The Family Connection, LLC not to testify or otherwise participate in any legal proceeding unless legally compelled to do so. We agree not to involve The Family Connection LLC in any legal disputes, especially a dispute concerning custody or custody arrangements (visitation, etc.). We acknowledge that if The Family Connection, LLC or any of its staff is subpoenaed regarding our care that we will be financially responsible for all costs associated as outlined on the Client Financial Agreement per hour for time spent traveling, preparing reports, testifying, being in attendance, and any other case-related costs.

The signatures below reflect that the parties agree to the terms set forth above.

_____	_____
Signature of Patient & Date	Signature of Patient & Date
_____	_____
Signature of Patient & Date	Signature of Patient & Date
_____	_____
Signature of Patient & Date	Signature of Patient & Date

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Couple/Family Policy

This statement of policy is intended to inform you, the participants in therapy, that when The Family Connection, LLC agrees to treat a couple or a family, we consider that couple or family (the treatment unit) to be the client. For instance, if there is a request for the treatment records of the couple or the family, we will seek the authorization of all members of the treatment unit before we release confidential information to third parties. Also, if our records are subpoenaed, we will assert the psychotherapist-patient privilege on behalf of the client (treatment unit).

During the course of our work with a couple or a family, we may see a smaller part of the treatment unit (e.g., an individual or two siblings) for one or more sessions. These sessions should be seen by you as a part of the work that we are doing with the family or the couple, unless otherwise indicated. If you are involved in one or more of such sessions with us, please understand that generally these sessions are confidential in the sense that I will not release any confidential information to a third party unless I am required by law to do so, or unless I have your written authorization. In fact, since those sessions can and should be considered a part of the treatment of the couple or family, I would also seek the authorization of the other individuals in the treatment unit before releasing confidential information to a third party.

However, we may need to share information learned in an individual session (or a session with only a portion of the treatment unit being present) with the entire treatment unit---that is, the family or the couple, in order to effectively serve the unit being treated. We will use our best judgment as to whether, when, and to what extent we will make disclosures to the treatment unit, and we will also, if appropriate, first give the individual or the smaller part of the treatment unit being seen the opportunity to make the disclosure. Thus, if you feel it necessary to talk about matters that you absolutely want to be shared with no one, you might want to consult with an individual therapist who can treat you individually.

This “no secrets” policy is intended to allow The Family Connection, LLC couple/family therapist to continue to treat the couple or family by preventing, to the extent possible, a conflict of interest to arise where an individual’s interests may not be consistent with the interests of the unit being treated. For instance, information learned in the course of an individual session may be relevant or even essential to the proper treatment of the couple or family. If we are not free to exercise our clinical judgment regarding the need to bring this information to the family or the couple during their therapy, we might be placed in a situation where we will have to terminate treatment of the couple or the family. This policy is intended to prevent the need for such termination.

By signing below, you, as members of the couple/family or other unit receiving treatment, acknowledge that each of you has read this policy, that you understand it, that you have an opportunity to discuss its contents with your therapist, and that you undertake couple/family therapy in agreement with this policy.

Signature_____ Date_____

Signature_____ Date_____

Signature_____ Date_____

Signature_____ Date_____

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THE FAMILY CONNECTION LLC
Creating Understanding - Connecting Families

2112 Main Street, Suite A
Los Lunas, NM 87031

Client Financial Responsibility Agreement

The Family Connection, LLC is committed to providing high quality mental health outpatient counseling. In order to do so, we expect payment at the time of service. The Family Connection, LLC will file insurance claims as a courtesy to those clients who are eligible for reimbursement through their insurance. However, the patient and/or financial/legal guardian are responsible for all fees associated with the services provided. We participate in many healthcare plans and work to provide each patient with a clear understanding of the patient's financial responsibility for services provided. The patient should understand they are responsible for payments – these payments can be made by the patient directly, by the insurance company or by a combination of both. Below is a listing of the approximate fees that may be associated with your care:

USUAL & CUSTOMARY FEE SCHEDULE:

Initial Consultation $140.00	Family Psychotherapy with patient $115.00
Individual Therapy Session (16-37 minutes) $60.00	Family Psychotherapy without patient $100.00
Individual Therapy Session (38-52 minutes) $100.00	Group Psychotherapy (per visit).....$55.00
Individual Therapy Session (53-60 minutes) $130.00	Psychotherapy for crisis, first 60 minutes $200.00
Evaluation of records (per/15 minutes).....$50.00	Crisis code, each additional 30 minutes $100.00
Preparation for court (minimum of 2 hrs) $250.00/hr	Report preparation (per/15 minutes).....$50.00
Records request .....$6.50 avg min, estimated upon receipt of written request, based on copying time, supplies & postage	Court testimony (first 2 hours).....$500.00/hr
	Court testimony (each additional hour).....$250.00/hr

I acknowledge that I have read and understand my obligations regarding the various options for reimbursement of services received at The Family Connection, LLC by initialing below:

( ) Cash Patient/Sliding Scale – I agree to pay the entire session fee (s) prior to services rendered. I agree to submit a complete, thorough and accurate reflection of my entire household income by submitting monthly paystubs etc, to determine financial eligibility for a discount on services. I understand that I am responsible for paying the entire session fee prior to services being rendered, in order to qualify for a sliding scale discount.

( ) Insurance Policy Coverage/Centennial Care - I understand that I am financially responsible for any applicable deductible, co-insurance or co-pays associated with my policy. I understand that my insurance plan may have negotiated specific rates for services rendered and I would be responsible for the cost my specific insurance has identified, provided my insurance covers the service. Should services be denied, I understand that I am responsible for all fees associated with my account and my care. I understand that my plan may have certain restrictions with regard to yearly visit limits, services covered, etc and understand that I am fully responsible for ensuring my insurance has the information they need to provide coverage for the claim.

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( ) Records Requests/Court Fees – I understand that I am responsible for all fees associated with records requests and/or court fees. I acknowledge that these fees will not be covered by my insurance policy.

FINANCIAL POLICY STATEMENT

1. I understand that I am responsible for paying the full amount of each therapy session. TFC accepts cash, Visa, MasterCard, Discover and Health Savings Account cards as well as payments by check and debit cards. Payments may also be made in person and over the phone.

2. I understand that I may make a payment myself, use insurance, or use a combination of these two methods to pay.

3. TFC reserves a time slot especially for the patient. I understand that The Family Connection, LLC requires 24 hours' notice of cancellation of a scheduled session. Failure to cancel within this period will result in a charge for the session up to the billable amount of $100/hour.

4. I understand that The Family Connection, LLC will file insurance claims as a **courtesy** to those clients who are eligible for reimbursement through their insurance. If my insurance plan includes a co-pay, I understand that I am responsible for paying the co-pay on the day of the session. If the co-pay amount changes, I understand that I am responsible for paying the new amount for all sessions covered by the change. If, at any time, my insurance company denies coverage, I understand that I am responsible for the full amount of the session(s) not covered by the insurance. I understand that if I have an insurance policy with an annual deductible, I may be responsible for the full amount of the session(s) until that deductible is met and that payment will be due at the end of each session. I understand that if the insurance company sends payment for services directly to myself, that balance must be sent or dropped off at The Family Connection at either the Rio Rancho or Los Lunas Office locations within 72 business hours of receipt.

5. I understand that I am responsible for notifying The Family Connection, LLC immediately of any changes in my insurance, including canceling a policy and/or plan changes. I also understand that I am responsible for paying all sessions according to those changes.

6. I understand that it is my responsibility to set up a payment plan as soon as possible, in the case there are financial difficulties interfering with my ability to pay. We will work with each client to create a suitable payment plan. The Family Connection, LLC expects that you adhere to the contract you establish and notify us if the payment contract would need to be renegotiated. We do utilize the services of a collection agency. I understand that The Family Connection, LLC will refer any balances over 60 days, not in a payment contract, to our collection agency and any fees associated with the collection agency, will be my responsibility. TFC reserves the right to require payment for services to be made at or before the time of service for outstanding balances over

$500. I further understand that TFC may refuse to see patients whose outstanding balances are over $500, and who are not making regular payments on the balance.

7. I understand that The Family Connection believes that the issues you have brought to counseling are important. We ask that you participate in this counseling contract by keeping the appointments you schedule.

8. The parent/guardian is responsible for payment of services rendered to your dependents account. I understand that it is the policy of the Family Connection that in circumstances where the parents share legal custody that both parents shall be responsible for the payment of services provided their child. I agree to accept that responsibility for such payments.

Attestation Statement:

I have read, understand, and agree to comply with The Family Connection, LLC Client Financial Responsibility Policy outlined above. I understand that I am responsible for all charges associated with my care, including but not limited to charges not covered by my insurance company, as well as applicable co-payments and deductibles. I acknowledge that these policies do not obligate The Family Connection, LLC to extend credit.

I authorize my insurance benefits to be paid directly to The Family Connections, LLC.

I authorize The Family Connection, LLC to release pertinent information to my insurance company when requested or to facilitate the payment of a claim.

_____

Patient / Responsible Party Print Date

_____

Patient / Responsible Party Signature Date

Patient Name _____ Patient DOB: _____

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Electronic Communication Consent by Non-secure Transmission

Patient Name _____ **DOB** _____

CELL #: _____ **EMAIL:** _____

This consent form is for the communication of Protected Health Information ("PHI") that The Family Connection LLC may transmit, without the written authorization of the client, as described in the Uses and Disclosures section of The Family Connections Notice of Privacy Practices.

It may become useful during the course of treatment to communicate by email, text message (e.g. "SMS") or other electronic methods of communication. Please be informed that these methods, in their typical form, are not confidential means of communication. If you use these methods to communicate with The Family Connection LLC there is a reasonable chance that a third party may be able to intercept and eavesdrop on those messages. The kinds of parties that may intercept these messages include, but are not limited to:

- People in your home or other environments who can access your phone, computer, or other devices that you use to read and write messages.
- Your employer, if you use your work email to communication with The Family Connection LLC.
- Third parties on the Internet such as server administrators and others who monitor Internet traffic.

CONSENT FOR TRANSMISSION OF PROTECTED HEALTH INFORMATION BY NON-SECURE MEANS

I, _____, hereby consent and authorize The Family Connection LLC to communicate my PHI through the following non-secure transmissions (please initial all of your choices):

_____ Cellular/Mobile Phone, including text messages

_____ Unsecured Email

I, _____, consent and authorize The Family Connection LLC to transmit the following PHI by the above selected electronic communications (please initial all of your choices):

_____ Information related to scheduling/appointments

_____ Information related to billing & payments

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_____ Information related to your mental health treatment (this may contain personal materials, forms, suggested articles, homework, etc.)

_____ My health record, in part or in whole, or summaries of material from my health record.

_____ Other information; Please describe: _____

I further understand that if I initiate communication via electronic means that I have not specifically consented to in this form, I will need to amend this consent form so that my therapist may communicate with me via that method.

I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. I understand that I am not required to sign this agreement in order to receive treatment. I also understand that I may terminate this consent, in writing, at any time.

_____ _____

Signature of client, parent or guardian Date

* Please complete ***only*** if you ***DO NOT*** consent to the above non-secure communication means:
I, _____, ***DO NOT*** consent to the transmission of PHI via unsecure means but would rather receive information about communication through a secure portal.
_____ (Please initial)