Policies and Informed Consent for Treatment

Welcome and thank you for considering Odyssey Counseling for your mental health needs. This document contains important information about our professional services and business policies. The policies and terms of this consent applies to both Odyssey Counseling and your specific provider.

Your Mental Health Provider: Your individual therapist is an independent contractor providing services to you pursuant to their agreement with Odyssey Counseling, LLC. Your therapist is an independently licensed mental health professional with one of the following active New Mexico licenses: LPCC, LMHC, LCSW, LMSW, LMFT, AMFT. Your therapist has no restrictions on his or her license.

Confidentiality: In general, discussions between a therapist and a client are confidential. No information will be released without the client's written permission unless mandated or permitted by law. Possible exceptions to confidentiality *include but are not limited to* the following situations: abuse or sexual exploitation; court orders or subpoenas; situations where the therapist has a duty to disclose or where, in the therapist's judgment, it is necessary to warn, protect, notify or disclose; information required by health insurance companies, Medicaid or others related to payment or authorization for health services; to employees or agents of Odyssey Counseling for operational purposes: to regulatory authorities in connection with compliance responsibilities; for treatment consultations with other mental health professionals when deemed necessary; to your primary care provider or other mental health provider for the purposes of continuity of care; and for fee disputes, licensing board complaints, or lawsuits between the client and the therapist or Odyssey Counseling. **For further information review the notice of privacy practices provided to you.**

By signing this Policies and Informed Consent for Treatment form below, **you are giving consent to the therapist and Odyssey Counseling to share information** with all persons mandated or permitted by law, with the agency that referred you, and the managed care company, Medicaid, and/or insurance carrier responsible for your health services and payment for your health services, and you are also releasing and holding harmless the therapist and Odyssey Counseling for any departure from your right of confidentiality that may result.

Length of Sessions: Sessions last 50 – 60 minutes but will vary depending on clinical needs. Therapists typically only see a client once a day. This mostly is due to stipulations by your insurance company. Emergency/crisis situations will be taken into

account.

Payment Policy: If you are insured, you agree that Odyssey Counseling will bill the insurance company and will accept payment from your insurance company at their rates for the services. You agree that any insurance carrier with whom you have a policy shall direct to Odyssey Counseling any benefits and payments related to services rendered to you by Odyssey Counseling providers. **You authorize and consent that Odyssey Counseling may provide your insurance company with any and all necessary information, including therapist notes, requested in connection with its review and consideration of the claim for payment of benefits. You are responsible for payment of all charges not covered by insurance, and any and all co-pays, coinsurance, deductibles, and any other payments are due at the time of service. You agree to notify Odyssey immediately of any changes in insurance.** If you have commercial insurance or pay out of pocket, you agree to have a credit card on file with Odyssey Counseling which you agree to be charged for any payments due (including missed appointment charges). If insurance is terminated or benefits are reduced for any reason, you acknowledge that you are responsible for the entire cost of the session ($90-$135) as well as any remaining balance on your account. I understand that services will be suspended or terminated if there's an account balance, and I've neglected to pay in full or make reasonable payment arrangements.

Cancellation Policy: There is a **$50 fee** for appointments missed or canceled with **less than 24 hours notice, or by Friday for Monday appointments.** You agree that the cancellation fee will be charged to your credit card on file. Multiple late cancellations or no-shows (except in cases of emergency) can result in termination.

By initialing I indicate that **I am aware of and will abide by the payment and cancellation policies** of Odyssey Counseling. _____ (Initials)

Text and Email Communication: There are inherent privacy and confidentiality risks with text and email communications. If you need to contact your therapist and choose text or email communication, you agree that you are fully aware of the risks and agree to hold Odyssey Counseling harmless for any resulting damages.

Emergencies: In case of a life-threatening emergency, call **911** immediately. For mental health crises, the **New Mexico Crisis Line** is available 24/7 at **1-855-NMCRISIS (662-7474).**

Relationship: In order to have successful therapy, the relationship with your therapist is to be strictly therapeutic and professional. Personal/business relationships undermine the effectiveness of the therapeutic relationship. You agree not to attempt to contact your therapist outside the scope of therapy, give gifts outside of a therapeutic context, seek to spend time together socially, seek to connect via social media unless deemed therapeutically appropriate by your therapist, or create any other kind of dual relationship with your therapist. If your therapist encounters you in a public setting, in order to protect your health information, the therapist will not acknowledge you unless addressed by you first.

Involvement in Treatment Plan: You and your therapist will discuss the goals, purposes and techniques of your therapy. You agree to communicate any questions or concerns you may have regarding the treatment recommended by your therapist and to communicate your input at the time the treatment plan is made and when it is revised from time to time.

Audio or Video Recordings: You acknowledge, and by signing this form, agree that neither you nor the therapist will record (audio or video) any sessions without the prior written mutual consent of the therapist and client.

Court Related Services: Odyssey Counseling does not provide or perform evaluations for custody, visitation, or other forensic matters. Therefore, it is understood and agreed that Odyssey Counseling cannot and will not provide any testimony or reports regarding issues of custody, visitation, or fitness of a parent in any legal matters or administrative proceedings. If Odyssey Counseling is contacted by an attorney regarding your treatment (either at your behest or related to a legal matter in which you are involved) **you agree to and acknowledge the following:**

- Odyssey Counseling charges a monetary retainer prior to any preparation or attendance of legal proceedings.
- Odyssey Counseling charges money per hour to prepare for and/or attend any legal proceeding and for all court related services.
- Charges for court related services are not covered by insurance. ● Court related services include talking with attorneys, preparing documents, traveling to court, depositions and court appearances.
- If the court or attorneys do not pay our fee, you will be charged for the time your therapist spends responding to legal matters.
- You will also be charged for any costs Odyssey Counseling incurs responding to attorneys in your case, including but not limited to fees Odyssey Counseling pays for legal consultation and representation by our attorneys.

Family Sessions: If you participate in family sessions, by signing this form you consent for Odyssey Counseling to maintain a single file for all joint sessions and to release all information contained in the file related to joint sessions upon request by a participant.

Complaints and Appeals: If you carry insurance and you have an issue with your care, you have the right to file a complaint or appeal. Some examples of a complaint are: The care you receive from an Odyssey Counseling provider; the time it takes to be seen by a provider; rude or inappropriate behavior by a provider or staff. An appeal can be filed when you do not agree with your insurance company's decision on payment. Odyssey Counseling cannot take any negative action against you for filing a complaint or an appeal. It would be advisable to try to resolve these complaints with the Clinical Director first who is Mary Baca, CWK, CCTP, RMT, LPCC

Rights and Responsibilities: If you are insured, you have rights and responsibilities

with your insurance. You have the right to:

- Get the facts about your insurance and your insurance company's services
- Be provided information about in-network providers
- Have privacy and be treated with respect
- Help make decisions about your care. You may refuse treatment.
- Receive a copy of your medical records, as allowed by law
- Request a change or correction to your medical records
- Discuss your treatment options with your provider in a way you understand
- Voice any complaints or send in appeals about your insurance provider or the care you were given
- Use your member rights without fear of adverse results
- Receive the member rights and responsibilities each year and suggest changes

You have the responsibility to:

- Give all the facts that my insurance providers and your providers need to care for you
- Know your health problems and take part in the joint decisions about treatment planning
- Keep appointments and be on time. If you are going to be late, call to let your provider know.

Consent to Treatment

I, _____, voluntarily agree and consent to receive (or agree for my child to receive) mental health assessment, care, treatment or services, and authorize an independent contract behavioral health provider of Odyssey Counseling to provide such care, treatment, or services as are considered necessary and advisable.

I understand that I will participate in the planning of my (or my child's) care, treatment, or services and that I may stop such care, treatment or services at any time.

I understand that I am consenting and agreeing to only those services that the provider is qualified to provide within the scope of the provider's license, certification, and training. If the client is under the age of 14 or unable to consent to treatment, I attest that I have legal custody of this individual and am legally authorized to initiate and consent to treatment on behalf of this individual.
By signing this Consent Form, I, the undersigned client (or parent) acknowledge that I have read this Policies and Informed Consent for Treatment document, understood, and agree to be bound by all the terms, conditions, and information it contains. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

SIGNATURE PAGE

_____

Client or Parent/Guardian Signature/Date

_____

Client Printed Name and DOB

_____

Witness Signature/Date

_____

Witness Printed Name