INFORMED CONSENT FOR ASSESSMENT AND TREATMENT

I understand that as a patient of **The Imagine Center for Psychological Health, Michael E. Behen, Ph.D., LP** I am eligible to receive treatment. The type and extent of treatment that I will receive will be determined following an initial assessment and thorough discussion. The goal of the assessment process is to determine the best course of treatment for me.

I understand that all information shared during treatment is confidential and no information will be released without my consent unless otherwise stated in the Privacy Practice Notice.

I understand that while psychotherapy may provide significant benefits, it may also pose risks. Psychotherapy may elicit uncomfortable thoughts and feelings, or may lead to the recall of troubling memories. I understand that **The Imagine Center for Psychological Health, Michael E. Behen, Ph.D., LP** will help me to work though any difficulties that may arise, but will not be held responsible for any negative consequences that are caused by such risks.

If I have any questions regarding this consent form or about the services offered, I may discuss them with my therapist. I have read and understand the above. I consent to participate in the evaluation and treatment offered to me by **The Imagine Center for Psychological Health, Michael E. Behen, Ph.D** I understand that I may stop treatment at any time.

_____ _____

Signature of Patient/Guardian Date

_____

Print Patients Name

_____

Print Guardian's Name (if applicable)

THE IMAGINE CENTER FOR PSYCHOLOGICAL HEALTH

Michael E. Behen, Ph.D., LP
4160 Woodward Ave., 2nd Floor Detroit, MI 48201
37625 Pembroke Ave., Livonia, MI 48152
42140 Van Dyke Ave. Ste 190, Sterling Heights, MI 48134

Patient Name: _____	Date of Birth: _____

Introduction

Telehealth involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary care practitioners, specialists, and/or subspecialists. The information may be used for diagnosis therapy, follow-up and/or education, and may include any of the following: patient medical records, images, live two-way audio and videos, and sound and video files.

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Expected Benefits:

- Improved access to medical care by enabling a practitioner to remain at a remote site while obtaining test results and consults from other sites.

- More efficient medical evaluation and management.

Possible Risks:

As with any procedure, there are potential risks associated with the use of telehealth. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient to allow for appropriate decision-making by the treatment professional.

- Deficiencies or failures of the equipment used to deliver telehealth services may lead to delays in evaluation and treatment.

- In rare instances, security protocols could fail, causing a breach of privacy of personal information.

INITIAL HERE AFTER READING: _____

By signing this form, I understand the following:

1. I understand that the laws that protect the privacy and confidentiality of health information also apply to telehealth and that no information obtained in the use of telehealth which identifies me will be disclosed without my consent.

2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.

3. I understand that I have the right to request all records obtained through the use of telehealth.

4. I understand that telehealth may involve electronic communication of my personal health information.

5. I understand that I may expect the anticipated benefits from the use of telehealth services in my care, but that no results can be guaranteed or assured.

Patient Consent To The Use of Telehealth

I have read and understand the information provided above regarding telehealth and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telehealth in my medical care. I hereby authorize The Imagine Center for Psychological Health to use telehealth in the course of my diagnosis and treatment.

Signature of Patient (or person authorized to sign for patient):

_____

Date:

_____

If authorized signer, relationship to patient:

_____

PATIENT FINANCIAL RESPONSIBILITY STATEMENT

Patient Name: _____

Patient Date of Birth: _____

Responsibility Party Name: _____

Relationship to Patient: _____

Responsible Party Date of Birth: _____

Responsible Party Mailing Address: _____

Responsible Party Email Address for Billing: _____

The services you seek at The Imagine Center imply a financial responsibility on your part. This responsibility obligates you to ensure payment in full for the services you receive. To assist in understanding that financial responsibility, we ask that you read and sign this form.

Feel free to ask if you have any questions regarding your financial responsibility. If someone else (parent, spouse, domestic partner, etc.) is financially responsible for your expenses or carries your insurance, please share this policy with them, as it explains our practices regarding insurance billing, copayments, and patient billing.

By signing below and/or by receiving services from The Imagine Center you agree:

1. You acknowledge and agree to the established policies and procedures of The Imagine Center, including but not limited to this PATIENT FINANCIAL RESPONSIBILITY STATEMENT.

2. You are ultimately responsible for all payment obligations arising out of your treatment or care and guarantee payment for these services. You are responsible for deductibles, co-payments, co-insurance amounts, or any other patient responsibility indicated by your insurance carrier or our Policies, which are not otherwise covered by supplemental insurance.

3. You are responsible for knowing your insurance policy. For example, you will be responsible for any charges if any of the following apply: (i) your health plan requires prior authorization or referral by a Primary Care Physician (PCP) before receiving services at The Imagine Center, and you have not obtained such authorization or referral; (ii) you receive services in excess of such authorization or referral; (iii) your health plan determines that the services you received at The Imagine Center are not medically necessary and/or not covered by your insurance plan; (iv) your health plan coverage has lapsed or expired at the time you receive services at The Imagine Center; or (v) you have chosen not to use your health plan coverage. If you are not familiar with your plan coverage, we recommend you contact your carrier or plan provider directly.

4. You will be required to follow all registration procedures, which may include updating or verifying personal information, presenting verification of current insurance, providing

signatures, and paying any co-pays or other patient responsibilities. Your card or other insurance verification must be on file for your insurance to be billed. If we do not have your card on file, or are unable to verify your eligibility for benefits, you will be treated as a self-pay patient. As a self-pay patient, our fee is expected to be paid in full at the time of service. If the insurance card or other necessary information is furnished after the visit, we may file a claim with your insurance; and, if paid in full by your insurance, you will be reimbursed. If you are not prepared to make your co-pay or other patient responsibility amount, your visit may be re-scheduled by The Imagine Center.

5. By signing below, you authorize The Imagine Center to verify your insurance benefits and submit your claim to your insurance carrier or other plan provider. You agree to facilitate payment of claims by contacting your insurance carrier or other plan provider when necessary. Without waiving any obligation to pay, you assign to The Imagine Center, for application onto your bill for services, all of your rights and claims for the benefits to which you or your dependents are entitled, under any federal or state healthcare plan (including, but not limited to, Medicare or Medicaid), insurance policy, any managed care arrangement or other similar third-party payor arrangement that covers health care costs and for which payment may be available to cover the cost of the services provided to you. You authorize The Imagine Center and associated staff to release patient information acquired in the course of your examination and/or treatment including but not limited to any and all medical records, notes, or other documents related to your treatment (including itemization of any charges and payments on the account) that is deemed necessary to process this claim to the necessary insurance companies, third-party payors, and/or other physicians or health care entities as they require to participate in your care. <u>It is important to notify us as soon as possible of any changes related to your insurance coverage. Failing to do so may result in unpaid claims, and you will be responsible for the balance of the claim. The Imagine Center does not accept responsibility for incorrect information given by you or your insurance carrier or other plan provider regarding your insurance benefits or benefit plans.</u>

6. If your insurance carrier does not remit timely payment on your claim, you will be responsible for payment of the charges within the terms set forth herein. Once your insurance carrier processes your claim, we will bill you for any remaining patient responsibility deemed by your insurance carrier. If any payment is made directly to you for services billed by us, you agree to promptly submit same to The Imagine Center until your patient account is paid in full. If you make a payment that results in a surplus on your account, you authorize The Imagine Center to apply the overpayment to any other account for which you are financially responsible, including your account, a member of your family's or dependent's account, or on any account for which you are a Financial Responsibility Party, and any remaining balance will be returned to the payor.

7. You will be emailed a billing statement that contains the total cost of your service(s) or procedure(s) received during your visit(s). If there is a problem with your account, it is your responsibility to contact The Imagine Center to address the problem or to discuss a workable solution.

8. Whether or not you have insurance or are self-pay, payment of any account balance is due within thirty (30) days of receipt of your billing statement. If any balance on your account is over ninety (90) days past due, your account will be in default and may be referred to a collection agency.

_____ Initials

9. We accept payment by check, cash, money order, debit cards or credit cards.

a. **Payment by Check.** If payment is made by check and it is returned or declined for any reason, your account will be charged a surcharge of $20.00 or up to the applicable state maximum legal limits, whichever is lower, in addition to any costs assessed or charged by any depository institution.

b. **Payment by Credit Card/Debit Card.** You may pay with a credit card or debit card, including Visa, Mastercard, American Express and Discover ("credit card"). Your payment with a credit card may be made in person, by mail, or by calling the number provided on your billing statement.

10. **Medicare.** The Imagine Center is a participating provider with the Medicare program and accepts as payment the Medicare allowable, patient deductible and/or 20% co-insurance. Medicare or secondary carriers do not cover some procedures and supplies. Please make certain you understand which aspects of your treatment are covered before proceeding. You understand that you will be responsible for your annual deductible, the co-payment, and any non-covered services specified by Medicare. By signing below, you request that payment of authorized Medicare benefits be made on your behalf to The Imagine Center for any services furnished to you by The Imagine Center.

11. **Medicaid.** If you are a Medicaid patient, you must present a valid eligibility card at the time of registration and prior to the time of service. Without verification of coverage, you will be responsible for the full/entire balance of your account. As a courtesy to you, your account will be billed to Medicaid when we receive all necessary information. You are responsible for non-covered portions and spend-down requirements associated with your individual coverage. If at any time you are not eligible for Medicaid coverage and wish to be seen, you will be treated as a self-pay patient and must make payment at the time of service

12. **Third Party Liability Injuries.** If you receive treatment as a result of a third-party liability injury (for example: motor vehicle accidents, premises liability, or other general liability claims against third parties), the balance for services rendered is considered due in full at the time of the service. Because The Imagine Center does not protect charges incurred relating to or arising out of third-party liability, we will not accept a delay in payment due to settlement disputes and/or litigation. We will not accept a letter of protection from an attorney as a guarantee of payment or assignment of third-party insurance payments. **The Imagine Center cannot act as administrator to resolve financial arrangements.** We may agree to bill a third-party insurance company of an at-fault party involved in an accident as a courtesy to you. To bill your claim directly, you must provide us all necessary information to confirm coverage for these payments with the auto/third-party carrier. We will also collect information about your personal medical insurance in case the auto/third-party carrier denies your claim. Regardless of whether we submit your claim to third-party insurance, as the patient, you are ultimately responsible for payment.

_____ Initials

13. **Additional Charges.** Patients may incur and are responsible for the payment of additional charges at the discretion of The Imagine Center including but not limited to: (i) charges for returned checks; (ii) charges for extensive phone consultations and/or after-hours phone calls requiring treatment
(iii) charges for copying and distribution of patient medical records; (iv) charges for extensive forms preparation or completion; or (v) any costs associated with collection of patient balances, all as allowed by law.

14. **Minor Patients.** The parent/guardian of a minor is responsible for payment of the minor's account balance. A minor who is not accompanied by a parent/guardian will be denied any non-emergency treatment unless charges for the treatment have been pre-authorized. Responsibility for payment of treatment of minor children, whose parents are divorced, rests with both parents. Any court-ordered responsibility judgment must be determined between the individuals involved, without the inclusion of The Imagine Center.

15. **Authorization to Contact.** You authorize The Imagine Center personnel to communicate by mail, answering machine messages, and/or e-mail according to the information provided in your patient registration information. The Imagine Center, or any agent or servicer of your patient account, may use any information you have provided, including contact information, e-mail addresses, cell phone numbers, and landline numbers, to contact you for purposes related to your account, including debt collection. You authorize The Imagine Center to use this information in any manner consistent with the information you have provided, including mail, telephone calls, e-mails, or text messages. You expressly consent to any such contact being made by the most efficient technology available, including automatic dialing/e-mailing or similar equipment, or pre-recorded or other messages, even if you are charged for the contact.

16. **Financial Responsibility Party.** If this or a separate The Imagine Center Financial Responsibility Statement is signed by another person, on your account, then that co-signature remains in effect until canceled in writing. Cancellation in writing shall become effective the date after receipt, and shall apply only to those services and charges thereafter incurred. By signing as Financial Responsibility Party, you hereby guarantee the full and prompt payment to The Imagine Center of all indebtedness of Patient to The Imagine Center, whether now existing or hereafter created (the "Indebtedness"); and you further agree to pay all expenses, legal or otherwise, incurred by The Imagine Center in collecting the Indebtedness, in enforcing this guaranty, or in protecting its rights under this guaranty or under any other document evidencing or securing any of the Indebtedness. This guaranty shall be a continuing, absolute and unconditional guaranty, and shall remain in force and effect until any and all said Indebtedness shall be fully paid. There shall be no obligation on the part of The Imagine Center at any time to first exhaust its remedies against Patient, any other party, or any other rights before enforcing the obligations of Financial Responsibility Party.

_____ Initials

Acknowledgement

By signing below, each of the undersigned acknowledges that: (i) I have been provided a copy of The Imagine Center PATIENT FINANCIAL RESPONSIBILITY STATEMENT; (ii) I have read, understand, and agree to their provisions and agree to the specified terms; (iii) I agree to pay all charges due (or to become due) to The Imagine Center for the below Patient's care and treatment, including co-payments and deductibles, as required or provided pursuant to my insurance plan and/or the insurance plan of another, as applicable; (iv) benefits, if any, paid by a third-party will be credited on the Patient account; (v) regardless of my insurance status or absence of insurance coverage, I am ultimately responsible for the balance on the account for any services rendered; (vi) if I failed to make any of the payment for which I am responsible in a timely manner, I will be responsible for all costs of collecting the money owed, including court costs, collection agency fees, and attorneys' fees (to the extent allowed by law); and (vii) failure to pay when due may subject me to late payment charges and can adversely affect my credit report.

I further agree that a photocopy of this Patient Responsibility Financial Statement shall be as valid as the original.

ONCE I HAVE SIGNED THIS AGREEMENT, WHETHER BY ORIGINAL, FACSIMILE OR ELECTRONIC (".PDF") SIGNATURE, I AGREE TO ALL OF THE TERMS AND CONDITIONS CONTAINED HEREIN AND THE AGREEMENT SHALL BE IN FULL FORCE AND EFFECT.

_____ _____

Responsible Party Signature Date