

CONSENT TO TREATMENT

- I have been given an opportunity to ask questions about this document.
- I consent to the terms and obligations described above.
- I agree to be fully responsible for the payment of fees for the services provided.

Signature

Date

MINOR CHILD

I/WE* consent that (name of child)

_____ may be
treated as a client by the Counseling & Wellness
Center.

Signature

Date

Signature

Date

Signature

Date

***Both parents must sign if court order
requires joint or shared decision-making.**

Please read carefully and sign.
Return to staff.
This will be kept in your file. _____

Pat Amos, APRN, BC

Psychiatric Clinical Nurse Specialist

Wes Crum, PhD

Licensed Psychologist – OH Psych #6520

Jessica Fox, MEd, PCC

Counselor – OH PCC # E-0900290-S

Eva Hill, MSW, LISW

Counselor – OH LISW #I-1000284-S

Michael Moore, MEd, LPCC

Counselor – OH LPCC #E-0500676

Dayna L. Pitzer, MSSA/LISW-S

Counselor – OH LISW-S #I-1451033-S

Dissatisfied with Our Services?

If you are having a difficulty with our services, we encourage you to call our Director, Stephen Givens, to see how we may assist in resolving the difficulty.

Ohio Board of Psychology

614.466.8808 | 77 South High Street Suite 1830

Columbus Ohio 43215-6108

Ohio Counselor, Social Worker, & Marriage & Family

Therapist Board

614.466.0912 | 77 South High Street Room 2468

Columbus Ohio 43215-6171

State Medical Board of Ohio

614.466.3934 | 30 East Broad Street, 3rd Floor

Columbus Ohio 43215

Ohio Board of Nursing

614.466.9564 | 77 South High Street Suite 400

Columbus Ohio 43215-7410



Meeting people at the intersection of their needs and goals.



Please read carefully and sign.
Return to staff.
This will be kept in your file.

The Counseling & Wellness Center Ohio
252 Main Street
Belpre, Ohio 45714

Tel 740.401.3088
Fax 844.318.0944

www.ohiocounselingandwellness.com

SESSIONS

Psychotherapy sessions are generally 50 minutes long and usually scheduled once a week.

AFTER HOURS

A therapist is available for NON-EMERGENCY calls at 304.420.1763.

For ALL EMERGENCIES call 911, or go to the closest emergency room for all emergencies.

FEES

Psychiatrist Level	\$320 Intake Med check fees vary
PhD Level	\$185.25 Intake \$163 therapy sessions
Master's Level	\$185.25 Intake \$163 therapy sessions
Psychological testing	Fees vary
Other services	Fees vary

Late Cancellation/No Show Fee

Appointments missed or cancelled with less than 24 hours' notice will be charged a \$50.00 fee, which is NOT billable to insurance. Should you need to cancel an appointment, a 24-hour answering service is available 7 days a week to take your calls.

CONFIDENTIALITY

Confidentiality is one of the most important elements of psychotherapy and one of your most important rights. Within certain legally defined limitations, any information revealed by you or learned about you from another source during the course of our work together will be kept strictly confidential, and will not be revealed to any other person or agency without your written permission. However, since this policy does have some exceptions, please read **BOTH** our **HIPAA Privacy Practices** and the following information carefully.

As you know, your health insurance company may help cover the cost of our services. In order for claims to be processed insurance companies require that we provide them with certain information, including a clinical diagnosis (some may require your treatment plan). Many



times this is done via the computer. All insurance companies claim to keep such information confidential, but once it is in their hands we have no control over what they do with it or who may see it. If you are concerned about this you may want to check with your insurance company before authorizing us to bill them.

You have the option of paying us directly, rather than using your insurance company and creating a record outside of this office.

If you are under 18, you should know that, in most cases, your parents can examine your records without your permission. However, we can refuse to allow such an examination unless court ordered.

There are certain situations in which we may be required by law to reveal information obtained during psychotherapy to other persons or agencies without permission.

- If, in our professional judgment, you threatened grave bodily harm to yourself or another person
- If we have reason to believe that a child or elder is being abused or neglected
- If we are court ordered to do so

In order to provide you with the highest quality services all of our therapists receive regular consultation from senior members of our profession with regard to their clients. Your identity will not be revealed.

COORDINATION OF CARE

In order to coordinate your healthcare, we request permission to let your Primary Care Physician or Psychiatrist know that you are a client of Counseling & Wellness Center.

- ☐ I consent _____
☐ I do not consent _____

Further disclosure to your doctor or any other party will require separate releases.

PAYMENT POLICY

Payment of deductibles, co-payments, co-insurance, and self-pay amounts are due at the time of service.

As a courtesy to you we will file your primary and secondary insurance.

- In divorce situations, the parent bringing the child to the Counseling & Wellness Center for care will be responsible for all charges during treatment.
- For any unpaid balance, we will first send a letter requesting payment or call to discuss payment options. We reserve the right to use a collection agency. No clinical information is given to collection agencies.

www.ohiocounselingandwellness.com