Consent to Treat/Acknowledgement of Financial Responsibility/Confidentiality Agreement

COUNSELING: is a confidential process designed to help you/your child address concerns, come to a greater understanding of oneself, and learn effective personal and interpersonal coping strategies. Counseling services at Springboro Pediatrics, Inc is intended to be short termed with brief interventions, solution-focused and could include a diagnostic assessment, psychoeducation, psychotherapy, family interventions, and/or referral.

BILLING: There could be separate costs associated with this service and it will be billed through your insurance. You should call your insurance carrier to verify Behavioral Health service coverage.

CONFIDENTIALITY: Springboro Pediatrics, Inc behavioral health consult recognizes that confidentiality is essential to effective counseling. We believe that for counseling to work best, you/your child must feel safe about sharing personal information with the therapist. Under most circumstances, all information about you/your child obtained in the counseling process (including your identity as a patient) is confidential and can only be shared with written consent. However, the following list describes circumstances in which we may share information about you/your child without consent.

• Information Released to other Springboro Pediatrics staff involved in your treatment. Most commonly, this would be your pediatrician.

• If you are under 13, your parents or legal guardian(s) have access to your records and may authorize their release to other parties. Those ages 13 and older must give written authorization to release their records.

• If you are reasonably suspected to be in imminent danger of harming yourself or someone else.

• If you disclose abuse or neglect of children, the elderly, or disabled persons or report being the victim of abuse.

• Upon the issuance of a court order or lawfully issued subpoena.

- Our Behavioral Health Consultant will not make recommendations in cases of custody.

CONSENT FOR TREATMENT: I voluntarily consent to the participation in counseling as part of Springboro Pediatrics services. I understand that by signing this form, I am allowing Springboro Pediatrics to bill my insurance and am agreeing to pay any copays or fees that will incur. I am also consenting to the confidentiality agreement.

Signature of Patient: ____

Signature of Therapist: ____

Signature of Patient's Guardian (if applicable): ____

Date: ______________________