



Anxiety and OCD Treatment Center of Ann Arbor

Providing evidence-based treatment across the lifespan

Therapy Evaluation Informed Consent Form

Welcome to the Anxiety and OCD Treatment Center of Ann Arbor. Due to very high demand for our services, we have a wait list for therapy evaluations (and a separate wait list for treatment). This form reviews our evaluation procedures.

Evaluation Appointment: Overview

The therapy evaluation is a comprehensive 1 hour, in-person meeting with one of our clinicians, billed to insurance (if your plan is accepted by our providers) or paid out of pocket. The purpose of the evaluation is to provide a comprehensive assessment of your potential anxiety and/or OCD symptoms. Our goal is to determine if treatment at our clinic will be helpful to you. Please note that we may determine at the evaluation that our clinic is not the best match for your therapy needs. We provide very specialized therapy, and not all presenting problems require - or benefit from - the therapy that we provide. In these cases, we provide recommendations for community providers who can deliver the evidence-based therapy that will best meet your needs. You will receive a list of our treatment recommendations after the evaluation is complete.

Evaluation Appointment: Portal and Measures

Once your evaluation appointment has been scheduled, we request that you complete all assigned measures on our secure patient portal. While these are extensive, they are essential to a more complete assessment of your symptoms over the lifespan and must be completed prior to the appointment.

After your evaluation appointment has been scheduled, our Office Manager will email you a link to create a password for your patient portal. **Please complete this step within 48 hours as the new patient account window will expire at that time.** After your account has been validated, you will have access to our new patient evaluation paperwork. **Please complete all assigned measures at least 24 hours before your evaluation to avoid cancellation of the appointment.** Please be aware that the patient portal is a best-practice, secure, encrypted medical records system. Electronic records are the current standard of care in all major medical clinics.

Evaluation Appointment: Wait Time

The wait time for an evaluation will vary depending on your schedule flexibility. **Please note that we only have daytime hours available for new clients.** Any prime time spots (4pm or later, weekends) are given to current clients that are being seen during the day while they wait for a primetime spot to be available.

Initial_____

Evaluation vs Treatment

As noted above, we have an initial evaluation waiting list, and a separate treatment waiting list. If the evaluation determines that therapy at our clinic will be helpful for you, you will be added to our treatment wait list. We strive to make the wait between evaluation and treatment as short as possible, but your

flexibility with appointment times will play the biggest part in determining the waiting time between evaluation and treatment.

Please note that while treatment recommendations will be provided at the evaluation session, no treatment is provided at the evaluation session. Treatment will not begin until you are assigned an individual provider, assuming we recommend treatment at our clinic. As mentioned above, we may refer you outside our clinic if we believe that will best meet your needs.

Evaluation Appointment: Confidentiality

In general, communications between a client and a behavioral health provider are private and legally protected. In most situations, we can only release information about your evaluation to others if you sign a written Authorization Form that meets certain legal requirements consistent with HIPAA guidelines. However, we are legally and ethically obligated to release information without your consent in the following situations:

- If a client presents an imminent danger to him/herself, we may be required to seek hospitalization for the client, or contact family members or others who can help provide protection.
- If there is cause to suspect a child under 18 is abused or neglected, or reasonable cause to believe that a disabled adult or an adult over the age of 65 is in need of protective services, the law requires that a report be filed with the appropriate agency. Once such a report is filed, additional information disclosure may be legally required.
- If there is reason to believe that a client presents an imminent danger to the health and safety of other(s), we may be required to disclose information in order to take protective action, including initiating hospitalization, warning the potential victim, and/or calling the police.
- It is our policy to have parents involved in the evaluation session. We do not conduct sessions with the child not present. However, the child does not need to be present for the entire session. We are not able to provide childcare. If a teen discloses information during the evaluation appointment, before giving parents any information, this will be discussed with the child, if possible, and an attempt will be made to handle any objections he/she may have.
- Children over the age of eighteen have the right to independently consent to and receive mental health evaluation (and treatment) without parental consent and, in that situation, information about the evaluation cannot be disclosed to anyone without the client's formal consent. Additionally, children over the age of 14 have the right to receive treatment per Michigan Mental Health Code guidelines. The minor may be seen for 12 outpatient therapy sessions or 4 months, whichever comes first, without parental knowledge or consent, provided there is no compelling need, such as probability of harm (drug abuse or suicidal/homicidal intent).

Evaluation Appointment: Client Rights

HIPAA provides you with various rights concerning your Clinical Evaluation Record as well as disclosures of protected health information. These rights include requesting that we amend your record; requesting restrictions on what information from your Clinical Records is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized;

determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to view and copy your records. Your clinician will be happy to discuss any of these rights with you. These rights are explained further in our Clinic's Privacy Notice. If you have a complaint, we encourage you to attempt to resolve it with your clinician. If the resolution is unsatisfactory to you, you may request to speak with the ownership team and or submit a complaint at www.anxietyannarbor.com/contactus.html.

If these are not satisfactory to you, you may contact the Washtenaw County Recipient Rights Office at (734) 544-3000 and ask to speak with the Rights Officer of the Day.

Evaluation Appointment: Clinical Supervision

Our clinic provides training in evidence-based treatment to limited license clinicians. A limited license clinician is qualified by the State of Michigan to deliver assessment and treatment services under the supervision of a fully licensed provider. You will be notified of the name and contact information of the fully-licensed clinician within our Center who is supervising your clinician.

Evaluation Appointment: Minor Clients (please initial the appropriate option for your child)

_____ The statement below does not pertain to (child's name) _____.

I am the:

_____ Sole Legal Custodial Parent

_____ Joint Legal Custodial Parent

_____ Legal Guardian

of (child's name) _____ and therefore I have the legal authority to enter this child into an evaluation appointment and to sign papers on the child's behalf. I understand that if there is joint legal custody with another person, that person may also be involved in the child's evaluation appointment and/or may receive communication from the evaluating clinician.

Evaluation Appointment: Payment and Cancellation Policy

Payment (copays, deductible, or full out of pocket fee) is due at the time of service. We accept checks, cash, and all major credit cards. Please note that while our clinic may provide an estimate of your insurance coverage, ultimately it is your responsibility to check with your insurance to see if they provide in-network coverage (or out of network reimbursement) for the evaluation session.

Due to the very high demand for our services and our extensive waiting list, we require **72 hours notice** for cancellations for evaluation appointments. This gives our Office Manager sufficient time to schedule another person into the evaluation slot. In addition, all of our clinicians are self-employed and often have existing clients waiting for appointment times. Late canceling or not showing to your evaluation appointment interferes with our ability to maximize our clinician's schedules and provide clinical care in the most efficient manner possible. To minimize the scheduling and financial impact of late cancellations, we require payment of the full evaluation fee if the session is not cancelled or rescheduled with at least 72 hours notice. **The full evaluation fee is currently \$235 for fully licensed psychologists, and \$200 for social workers and limited licensed psychologists.** To ensure this fee is paid, we require a credit card be placed on file in the event you do not cancel your evaluation appointment with sufficient notice. No other charges will be made to this card without a separate written consent form.

If you have questions regarding this process, please contact our Office Manager. We thank you for your understanding.

Evaluation Appointment: Credit Card Consent

I, _____, do consent to allow my provider(s) with the Anxiety and OCD Treatment Center of Ann Arbor to store my credit/debit* card information on file for myself and/or my child for the purpose of processing the full session fee for a LATE CANCELLATION (under 72 hours notice) or NO SHOW for the INITIAL EVALUATION APPOINTMENT. I understand that such information will be stored in a secure manner, just as my (or my child's) medical and other record is stored securely at the clinic.

***Please note than an FSA or HSA card CANNOT be used for the purpose of a missed or late cancellation fee.**

The credit/debit card information I would like my provider to use is as follows:

- Visa Mastercard American Express Discover

Client's Name _____

Name on the Card _____

Card Number _____

Expiration Date _____ Billing Zip Code _____

CVV (last 3 digits on back of card for Visa, MC & Disc; four digits on front of card for Am Ex) _____

I understand the following:

- ◇ I will be charged for the full evaluation session fee if I do not cancel the appointment 72 hours before the appointment time, or if I no show to the appointment
- ◇ The late cancellation/no show fee cannot be billed to insurance
- ◇ My credit card will **only** be used for the purpose of charging a late cancel/missed appointment fee for the Evaluation Appointment. If I begin treatment at the clinic and would like to keep a credit card on file for payment of copays/deductible/coinsurance amounts, I will complete the Center's standard Credit Card Authorization form, which is a separate form from this one.
- ◇ I may revoke this consent at any time by providing sufficient written notice. I understand that my consent is not considered fully revoked until the Clinic confirms receipt of said notice.
- ◇ If my card information changes, I will update the Clinic.
- ◇ If the card listed above is not the client's own card (i.e., in client's name), I consent to the Clinic contacting the card holder if needed to discuss billing matters, should billing issues arise. The card holder can be contacted via phone at _____.

My signature below indicates that I have reviewed all information in this Consent to Evaluation. My signature also indicates that I have reviewed the Clinic's cancellation policy information and agree to the Credit Card Charge consent terms.

Client name

Witness name

Client Signature Date

Witness Signature Date

Parent/Guardian Name

Parent/Guardian Signature Date