CONSENTS AND AUTHORIZATIONS

Felicia Glick-Oberwise, MSW,LCSW
Psychwise Services

Treatment and Policy Consents

1) I have the legal right to authorize and herby consent for services for myself or my dependent with Felicia Glick- Oberwise, LCSW which includes evaluation and psychotherapy.
2) I understand that **appointments not cancelled** at least 24 hours in advance will be billed to the Responsible Party at a rate of **$110.00** and cannot be billed to insurance.
3) I understand that follow up treatment is required to maintain ongoing quality care. If I fail to follow up with Felicia Glick-Oberwise LCSW within a 4 month period my case will automatically become "inactive or closed". If after 6 months, I wish to return to treatment, a new evaluation will be required by Felicia Glick-Oberwise, LCSW.
4) I understand that Felicia Glick-Oberwise, LCSW may refer me or my family members to clinicians or other outside services if she feels her level of expertise is not the most appropriate treatment. I understand that clinicians are ethically bound to refer out if they feel they can no longer effectively treat me or my family member and will refer me to another agency, facility or program that can better meet my needs.
5) The Psychwise Services Web site is available for general information as well as scheduling appointments. Felicia Glick-Oberwise, LCSW does not use general email, texting, or the website for patients to communicate clinical or urgent concerns. I understand **that I must contact Felicia Glick-Oberwise, LCSW by phone for all patient clinical or urgent** concerns.
6) I have received a copy of the Notice of Privacy Practices and understand and agree to my responsibilities as a patient receiving services from Felicia Glick-Oberwise, LCSW. **_____** ***(Initial Here)***

Financial Consents / Authorization

1. I have completed the demographic and insurance information on the Registration Form to the best of my knowledge and I authorize Felicia Glick-Oberwise, LCSW and her billing staff to release my medical information (including types of services, dates/times of services, diagnosis along with treatment plans, progress of treatment, case notes and summaries, if necessary) to process my insurance claims.
2. As a courtesy to patients, Psychwise Services may attempt to contact your insurance company to obtain benefit information for your care. Benefit information given to Psychwise Services is not a guarantee of payment by your insurance company. Often it is only an estimate.
3. I assign all medical and mental health benefits to which I am entitled, private insurance and any other insurance programs or EAPs to Felicia Glick-Oberwise, LCSW. This assignment will remain in effect until revoked by me in writing. I understand that I am responsible for all charges, whether paid by insurance or not and that I will be responsible for any amounts that remain uncollected by Felicia Glick-Oberwise, LCSW or her billing staff.
4. There maybe circumstances where services rendered to you may not be covered by any 3rd party payors, including but not limited to certain types of treatment; phone sessions; Skype sessions (or other video services); missed sessions or sessions canceled without 24 hour notice and the like. And if Felicia Glick -Oberwise LCSW is called upon to participate in any legal proceedings, administrative proceedings or investigation or the like, I understand I will be billed at a private pay rate **of $110.00 per hour**. And this document binds me in contract to pay for such services that were not reimbursed.
5. I understand that failure to keep current with payments may cause an interruption in treatment services until the balance due is paid or a payment plan is arranged.
6. I understand it is my responsibility to notify Felicia Glick-Oberwise, LCSW promptly if there is contact from my insurance company to me; or any changes to my insurance information. Failure to do so may result in non-payment by insurance.
7. I understand I will be given documentation to file claims with my insurance company if I wish to file on my own behalf. If Felicia Glick-Oberwise, LCSW has a contract with my insurance company at the time of my office visit, than she or her billing staff will bill my Insurance company for the provider portion. However, deductibles, co-pays and / or applicable fees are due at the time of my office visit. Cash, Checks and Credit Cards (American Express, Visa, MasterCard and Discover) are accepted. There will be $30 return check fee for any checks returned by the bank.
8. **Minors. (Under age 18).** If you are a parent and are not able to accompany your child who is a patient to the appointment, then the **Financial Agreement and Credit Card Authorization Form will utilized.** In situations of divorce, it is the accompanying parent's responsibility to make payment at the time of service.
9. I understand that in the event fees are not paid in a timely manner, collection agencies may be utilized in collecting unpaid debts. There will be a charge of 30% for administrative costs should your account be turned over to a collection agency.

I have read, understood, and agree to the consents and authorizations listed above.

_____/_____/____ _____/_____/____
Signature of Patient (age 12 and older) Date Signature of Responsible Party Different than Patient Date

_____ _____/_____/____
Print Patient Name Witness Date