Willow Grove Mental Health
14211 E. 4th Avenue, Suite 3-138
Aurora, CO. 80011
(720) 262-9100
(720) 262-9101

# Disclosure and Consent to Treatment

**Consent to Treat**: I consent to and authorize Willow Grove Mental Health, Inc. (further referred to as the practice) and its healthcare team to perform mental health care evaluation and treatment as deemed medically necessary and in their professional judgment.

**Confidentiality**: I understand that my records will be held in confidence according to the Colorado Revised Statutes [CRS section 12-43-218, the code of Federal Regulations 42 C.F.R. Part 2) and the practice's Notice of Privacy Practices. Exceptions to the rule of confidentiality, such as danger to self, danger to others, grave disability, child or elder abuse or neglect, court order, acts of terror, or in response to any legal action taken by you against the practice, among others, may arise during the course of treatment.

**Destruction of Records**: I understand that the clinical records may be destroyed if no further treatment is rendered within 7 years of the date of termination of the episode of treatment. Pediatric records are destroyed 7 years after turning 18 regardless of treatment termination date.

**Assignment of Benefits and Release of Information:** I agree to be responsible for my co-payment, deductibles, or other charges for services not covered by insurance or other third-party payors except as prohibited by any agreement between my insurance company and the practice or by state or federal law. I authorize the practice to file any claims for payment of any portion of my bill and assign all rights and benefits payable for services to the practice C until final payments are made. I authorize the practice to release any information necessary, including mental health/substance abuse records, to process claims as required by my insurance company or third-party payors until final payments are made.

**Controlled Substances:** If I or my child is prescribed controlled substances (Schedule II medications), I agree to follow the controlled substance policy of the practice which may include urine drug screens. Early refills will not be provided for controlled substances unless it is authorized by your provider.

**Prescriptions and Refills**: Refill requests will be processed in 48 business hours. Prescriptions will not be refilled on the weekend. Please plan accordingly for your refills.

**Prior Authorizations**: Prior Authorizations for prescriptions require 3-5 business days to process. Have your pharmacy fax a prior authorization request to 720-262-9101 for any authorizations.

**Communication Consent:** Only direct phone calls, letters, and communication via the patient portal and our telehealth platform are subject to the most stringent security protections under the HIPAA Privacy Rule. If I choose to communicate with my provider by email, text message, Skype, Facetime, or if my provider deems in-vivo exposures necessary, I acknowledge and accept the risk of inadvertent disclosure of my own Protected Health Information due to less stringent security protections. 45 C.F.R § 164.522(b): A covered health care provider must permit individuals to request and must accommodate reasonable requests by individuals to receive communications of protected health information from the covered health care provider by alternative means or at alternative locations.

Patient Name: _____ Date: _____

Signature of Patient or Legal Guardian: _____

Willow Grove Mental Health
14211 E. 4th Avenue, Suite 3-138
Aurora, CO. 80011
(720) 262-9100
(720) 262-9101

First and Last name: _____
Preferred name: _____
Address: _____
_____
_____
Phone: _____
Birthdate: ____/____/_____
Marital Status: _____
Email: _____
Referral Source: _____
License plate number: _____
Make/Model of vehicle: _____

Emergency Contact Information:
** This person will be contacted in the event of a mental health emergency
Emergency contact name: _____ Relationship: _____
Emergency Contact phone: _____

Insurance Information:
Insurance: _____ PPO/HMO (please circle)
Individual ID: _____
Group ID: _____
Insurance Subscriber: Self/Other (please circle)
If other, please indicate:
Subscriber's name: _____
Address: _____
_____
_____
Phone: _____
Birthdate: ____/____/_____

Willow Grove Mental Health
14211 E. 4th Avenue, Suite 3-138
Aurora, CO. 80011
(720) 262-9100
(720) 262-9101

# Willow Grove Mental Health Financial Policy

**Client Financial Responsibility**: All fees are due at the time of service. I understand that the Willow Grove Mental Health, Inc. (further referred to as the practice) may revise the fee schedule at any time. I agree to pay all costs including reasonable attorney fees in the event the practice refers unpaid fees for collection. If and when there are changes to my insurance coverage or financial situation that will impact my financial obligations, I will notify the practice and make alternate financial arrangements for services. Failure to honor financial obligations may result in discharge from the practice and non-renewal of prescriptions.
**Insurance Fee Schedule:** If your provider is in-network with your insurance company, your visit will be billed to your insurance. Clients are responsible for all co-pays and deductibles associated with insurance. Failure to pay copays or deductibles will result in discharge from the practice and non-renewal of prescriptions. Please note that EMDR sessions may not be covered by your insurance.
**Self-Pay Fee Schedule Nurse Practitioner and Medication Management Services:** Initial evaluation 90 minutes: $300.00; Therapy Session 50 minutes $200.00; Medication Management 25 minutes $120.00.
**Self-Pay Fee Schedule Therapy Services:** Initial evaluation 60 minutes: $160; Therapy sessions 50 minutes: $130; EMDR sessions 90 minutes $180
**Urgent Appointments:** Urgent Appointment (within 24 hours of contact) 150% of session fee
**Failure to Pay:** Late Fee (after 30 days of balance due): $15; Late Fee (after 60 days of balance due): $30. The practice reserves the right to send any individual to collections for failure to meet financial responsibilities
**Court Fees**: $300/hour for non-expert testimony and $500/hour for expert testimony
**Copies of Records**: Medical records exceeding 30 pages will be charged $.50 per page.
**Forms**: Disability and legal paperwork will be billed at 15-minute increments at the clinician's hourly rate
**Cancellation and No-Show Policy**: I agree to notify the practice 24 hours in advance of any cancellation or on Friday for a Monday appointment. Failure to provide 24 hours' notice of cancellation will result in a charge of 50% of the session fee for the first instance and the full fee for any additional instance. No shows will be charged the full fee for the session. These charges are not covered by insurance.
**Credit Card on File:** By putting credit card information on file, I agree to allow the practice to automatically charge the card for all appropriate services rendered including session fees, deductibles, copays, no show fees, late cancellation, and late fees.
**Balance Billing**: As of January 2020, in Colorado it is illegal to balance bill. This means we can only bill for the outstanding balance of the negotiated rate. The remaining negotiated rate is the patient's responsibility.

**I understand that I will be charged for late cancellations and no-show appointments.**

Patient Name: _____ Date: _____

Signature of Patient or Legal Guardian: _____

---

Credit Card Information to Keep on File for Billing Purposes

Card # _____

CSC Code: _____ Expiration Date: _____

Billing Zip Code: _____

Willow Grove Mental Health
14211 E. 4th Avenue, Suite 3-138
Aurora, CO. 80011
(720) 262-9100
(720) 262-9101

# ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I, _____, have received a copy of the Notice of Privacy Practices for Willow Grove Mental Health, Inc.

Patient Name: _____

Signature of Patient or Legal Guardian: _____

Date: _____

# TELEMEDICINE CONSENT

- I understand that the patient may refuse telemedicine services at any time, without loss or withdrawal of treatment.
- I understand all applicable confidentiality protections shall apply to these services
- I understand that the patient shall have access to all medical information from the services under state law.

Signature of Patient or Legal Guardian: _____

Date: _____

Willow Grove Mental Health
14211 E. 4th Avenue, Suite 3-138
Aurora, CO. 80011
(720) 262-9100
(720) 262-9101