LEGACY COMPREHENSIVE COUNSELING & CONSULTING
19751 E. MAINSTREET SUITE 215 - PARKER CO 80138
WWW.LEGACYPARKER.COM - PHONE: 303-841-4005
OR INFO@LEGACYPARKER.COM

INFORMED CONSENT AGREEMENT

I acknowledge that I have discussed and understand information regarding the therapy I am considering. The risks and benefits of treatment have been discussed with me. I have had all my questions answered fully. I wish to be seen as a client for psychological services provided by Legacy Comprehensive Counseling & Consulting. These psychological services may include individual and family therapy, ABA therapy, group, and/or psychological testing.

I give my permission to my therapist at Legacy Comprehensive Counseling & Consulting to observe and to keep records of treatment contacts and sessions with me. I understand that developing a treatment plan with my Legacy therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process. I understand that no promises have been made to me as to the results of treatment or of any procedure provided by Legacy. I understand that I cannot make audio or video recordings at any time during my treatment at Legacy. This includes, but is not limited to recording devices from cameras, cellular phones, iPhones, etc.

I understand that Legacy is a multi-disciplinary team including child psychologists, master level therapists, pre-doctoral interns/externs, registered psychotherapists, post-doctoral level therapists, certified behaviorists and behavior technicians. I understand that my therapist may discuss my treatment plan, diagnosis, and progress with the other Legacy providers and supervised interns/technicians (if applicable) for the purpose of consulting, teaching, and/or treatment planning. I understand that all Legacy therapists, providers, interns, and employees are held to the same limits of confidentiality as my primary therapist.

I am aware that I may stop my treatment with my Legacy therapist at any time. The only thing I will still be responsible for is paying my outstanding balance on services I have already received or the addition of late fees on an outstanding balance from services received. If I decide to stop treatment, I understand that I will need to cancel any future appointments that I have scheduled at Legacy with the Legacy receptionist in order to avoid late cancel or no-show charges accruing on my account after I decide to stop treatment.

I know that I must call to cancel an appointment at least 24 hours before the time of the appointment. If I do not cancel or do not show, I may be charged a fee for that missed appointment (if a third party payer is involved, their direction will be followed). I also understand that if I am 15 minutes late for any scheduled appointment the appointment will need to be rescheduled. In this occurrence I understand that I will also be charged for a $50 late cancel fee.

I am aware that an agent of my insurance company or other third-party payer may be given extensive information about the diagnosis, progress, discharge, cost(s), dates(s), and providers of any services or treatments that I receive. I understand that if payment for the services I receive here is not made, the therapist may stop my treatment. Additionally, I understand that the therapist's billing agent and administrative assistant will have access to my contact information, as well as certain clinical data necessary for billing purposes.

Client/Guardian Initials _____

I understand that I may not be able to reach my therapist at all times. In the event of an emergency, my alternative contacts are my family physician and emergency services at a hospital.

The confidentiality of all materials related to my treatment will be protected by Legacy except in the following situations:

1. if I give my written permission for information to be shared with another agency or person,
2. information required by my insurance company for billing purposes (this may include procedures and diagnoses)
3. if there is a suspicion of neglect or abuse of a child or an elderly person,
4. if I (or my child) threaten(s) to seriously hurt myself (him/herself) or someone else.
5. if my records are subpoenaed by court of law.
6. if my account is overdue by 90 days or more, Legacy may be obligated to turn past due accounts to a contracted collection agency or seek collection with a civil court action.

My signature below shows that I understand and agree with all of these statements.

Signature_____ Printed Name_____ Date _____
Client's Signature (15 years or older)

Signature_____ Printed Name_____ Date _____
Signature of Parent, Guardian or Personal Representative (if patient under 15)

I, the therapist, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

Signature_____ Date _____
Therapist's Signature, Legacy Comprehensive Counseling & Consulting