Legacy Psychological Services, LLC

7105 Hamilton Ave., Cincinnati, OH 45231
Phone (513) 522-0777, Fax (513) 522-4577
Legacymentalhealth.com

Consent for Psychological Services

Client name:_____ Date of Birth _____ Date:_____

Treatment
I hereby consent to appropriate psychological services including but not limited to diagnostic/evaluation procedures, counseling, treatment, consultation, and telehealth services by Legacy Psychological Services, LLC. I also release Legacy Psychological Services, LLC, and hold it harmless for rendering the above procedures.

Telehealth
I understand that services may be provided through telehealth communication methods in lieu of in-person appointments. Secure communications will be used whenever feasible; however, use of telehealth may pose a potential risk to confidentiality and unpredictable disruptions may occur. A back-up plan may be created to prepare for possible disruptions. An emergency safety plan including notification of emergency contacts and identifying the closest emergency room may be created in case of a critical situation arising during a telehealth appointment. I understand that telehealth may not be appropriate in some situations, in which case a more appropriate plan of care may be discussed.

Billing
I acknowledge that the client is responsible for payment of fees associated with services provided by Legacy Psychological Services, LLC. If health insurance or HMO benefits are used, I authorize benefits to be made on the client's behalf to Legacy Psychological Services, LLC for services provided. I also authorize Legacy Psychological Services, LLC to bill and receive payments from the client's secondary insurance carrier or HMO for covered services.

I permit the release of necessary client information to the Health Care Financing Administration, the appropriate managed care entity, or the agents of any psychological or medical organization required to determine client eligibility and benefits for psychological services.

The undersigned acknowledges that the client is responsible for that portion of the allowable fees not paid by the insurance carrier. If the client is a member of an HMO, the undersigned acknowledges that the client is responsible for the deductible and co-payment as outlined in the plan. If the client has Medicaid, I understand that the client is not responsible for any portion of the procedural charges. I understand that no show or late cancellation fees are not covered by insurance plans. A reasonable estimate of fees may be discussed at the outset of treatment.

SIGNATURE _____

PRINTED NAME _____

RELATIONSHIP ◉ Self ○ POA ○ Guardian ○ Parent

Revised 2/2022