Facility Consent for Psychological Services

Client name:_____ Facility:_____ 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 will release Legacy Psychological Services, LLC, and hold it harmless for rendering the above procedures provided that they are rendered in accord with professional, ethical, and legal standards.

***Telehealth** - I understand that, due to public health emergencies, in-person appointments at facilities may not be safe or feasible, and thus temporarily suspended. Secure communications will be used whenever feasible; however, given the nature of digital communication, use of telehealth may pose a potential risk to confidentiality and unpredictable disruptions may occur. A back-up plan is created to prepare for possible disruptions. An emergency safety plan is created in case of a crisis situation including notification of facility staff, emergency contacts, and identifying the closest ER. I understand that telehealth is not appropriate for all problems and the therapist may decide that telehealth is no longer appropriate in which case a more appropriate plan of care will be discussed.

Billing

I acknowledge that the client has **MEDICARE PART B INSURANCE, MEDICAID** or a **MEDICARE/ MEDICARE HMO** health insurance plan. 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 COMPANY** 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.

IF THE CLIENT HAS MEDICARE PART B, the undersigned acknowledges that the client is responsible for that portion of the Medicare allowable fees not paid by Medicare Part B. If the client is a member of a Medicare HMO, the undersigned acknowledges that the client is responsible for the 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 charges.

SIGNATURE _____

PRINTED NAME _____

RELATIONSHIP _____
(Self, POA, Guardian, etc.)

WITNESS _____

10/2020

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