REVISED 12/15/2022

Informed Consent for Treatment

Financial Consent & Insurance Billing

I voluntarily consent on behalf of myself or my legal dependent to participate in evaluation, consultation, and/or treatment as a patient of The Collective. I give my authorization to receive treatment and I understand that developing a treatment plan with my clinical team and regularly reviewing our work toward meeting goals is in my best interest. I agree to play an active role in this process and understand that I may address any concerns with my clinical team in a timely manner. I understand that no promises have been made to me as to the results of treatment or of any procedures provided by The Collective. I am aware that I am free to choose treatment and may stop treatment at any time. I understand that if I choose to stop treatment, I will still be financially responsible for the services I have already received.

This agreement shows my commitment to pay for the treatment I receive. I agree to pay for the services rendered at each session or in accordance with an established payment plan. Insurance may cover part, or all the cost of treatment, and I understand that The Collective will attempt to charge the correct copay or allowable amount at time of service. However, I understand that it is **my responsibility to check my coverage and be knowledgeable about my benefits.** I also understand that there may be some types of treatment that may not be covered by insurance but may be clinically recommended. Unless otherwise specified, by me, I agree to allow submission of insurance claims to insurance (if appropriate) – this includes diagnoses and treatment information. I authorize payment of benefits to The Collective.

Out-of-Network & Out-of-Pocket

Medical Services

60-minute medication management session: **$200**

30-minute medication management session: **$150**

Therapy Services

60-minute intake session: **$200**

60-minute psychotherapy session: **$150**

60-minute group psychotherapy session: **$50**

Documentation Requests

Documentation requests must be made utilizing the following secure methods:

https://requestmanager.healthmark-group.com/register
https://www.collectivebh.com/request-medical-records/
Phone: 800-659-4035

Email: status@healthmark-group.com
All documentation requests will be handled within 30 calendar days.

Documentation requests, including, but not limited to, medical records, legal letters, accommodation letters, short term disability paperwork, detailed treatment summaries, IEP documentation, ESA letters, may incur a fee based upon length, time spent, and clinicians involved.

Fee Policy

I understand that I must call to cancel an appointment **at least 48 hours** (2 business days) before the appointment time (weekend days and holiday days do not count towards the minimum 2 business day requirement). If I do not cancel or do not show up, I will be charged **$100** for individual appointments and **$50** for group appointments. I agree to pay for appointments that are not cancelled or those where I fail

to give proper notice that I will not attend. Certain exceptions for unforeseen or unavoidable situations can be made at the exclusive discretion of The Collective. I understand that insurance does not pay for appointments that are not cancelled, so I will be solely responsible for the cost. **Fees will also apply to late arrivals and requests for abbreviated appointments.**

Patient Rights & Important Information

1. Generally, the information provided by and to me during therapy sessions is legally confidential. Whenever the information is legally confidential, the clinician cannot be forced to disclose the information without your consent.

2. There are exceptions to the general rule of legal confidentiality. These exceptions are listed in the Colorado statutes (C.R.S. 12-43-218). Be aware that legal confidentiality will not apply in a criminal or delinquency proceeding, except as provided in section 13-90-107 C.R.S. There are other exceptions: the clinician will identify these to me as the situations arise during therapy, but, briefly, these are (1) imminent threat of bodily harm to self or identifiable other; (2) gravely disabled, as a result of a mental disorder; (3) child/elder abuse or neglect; (4) When you or your representative files a lawsuit or grievance against your clinician (5) a court order requiring The Collective to turn over records; (6) if you are in treatment by order of a court of law, the results of the treatment ordered must be revealed to the court; (7) if there is suspected threat to national security to federal officials, the clinician is required to report this to law enforcement. The clinician is not required to inform you of actions in this regard, however, if a legal exception arises during therapy, if feasible, you will be informed accordingly.

3. Under Colorado law, minors under 12 years old (for therapeutic services) and under 15 years old (for medical services) have the right to consent to their own treatment. Generally, except for situations such as those mentioned above, information provided by a minor during therapy sessions is legally confidential and will not be shared with parents or guardians. This includes activities and behavior that your parent/guardian would not approve of—or would be upset by—but that do not put you at risk of serious and immediate harm. However, If the therapist, in their professional judgment, believes that you are in danger, they will communicate this information to the parent or guardian.

4. Under Colorado law, parents of children under 12 years old (for therapeutic services) and under 15 years old (for medical services) have the right to access mental health treatment information concerning their minor children, unless the court has restricted access to such information, including but not limited to adjudication of parental medical decision-making authority. If you request treatment information, I may provide you with a treatment summary, in compliance with Colorado law and HIPAA standards.

5. The Collective prohibits harassment of any kind, in person, via email, or via phone, and will take appropriate and immediate action in response to complaints or knowledge of violations of this policy. For purposes of this policy, harassment is any verbal or physical conduct designed to threaten, intimidate or coerce an employee, co-worker, or any person working for or on behalf of The Collective. Violation of this policy could lead to your dismissal.

Telehealth Behavioral Contract

1. Confidentiality cannot be guaranteed by the clinician in a virtual platform. You understand that you need to be in a quiet, private setting wherein they will not be overheard and can speak freely.

2. You understand that telehealth services bring with them the risk of technological difficulties and The Collective will do everything possible to address any issues on our end during a session. Sessions will not be extended due to technological difficulties. You understand that you have the responsibility to ensure a good connection is available for your appointment times.

3. Your clinician must know your location during every telehealth session. You agree to provide your address or location for these sessions. You agree to inform the clinician if this changes at any point throughout your care. I understand that The Collective cannot provide virtual care to patients that are located out of state.

4. You agree to take telehealth sessions seriously and present as you would in an in-person session. This includes, but is not limited to, being on time, having devices turned off, being appropriately dressed, and focusing fully on the session. You agree that you will not use substances during a telehealth therapy session.

5. Teletherapy sessions may be discontinued at any time by the therapist or by the patient if these standards are not met.

In Case of Emergency

The Collective does not provide emergency services and is not available 24/7. If I find myself or my child in a life-threatening situation, I agree to take the necessary steps to keep myself and my child safe, up to and including calling 911, going to an emergency room, or contacting the Colorado Access Crisis Line:

Colorado Access Crisis Line: (844) 493-8255 or Text: 38255

I have read and understand the above statements, I understand my rights as a patient, and consent to evaluation/treatment. If treatment is for a minor, I also attest that I am the legal guardian and have the right to consent for the treatment of this child. I understand that I have the right to ask questions of the service provider about the above information at any time.

_____	_____	_____
Patient's Signature	Patient's Printed Name	Date
_____	_____	_____
Guardian's Signature, 1 (if applicable)	Guardian's Printed Name, 1	Date
_____	_____	_____
Guardian's Signature, 2 (if applicable)	Guardian's Printed Name, 2	Date