PHOENIX HEALTHCARE OF VIRGINIA
PATIENT'S STATEMENT OF RIGHTS AND RESPONSIBILITIES

INFORMED CONSENT

The following information is provided to ensure a clear and mutual understanding of your rights and responsibilities as a patient when under the care of Phoenix HealthCare of Virginia. Please read this information carefully. You may ask about any information that is not clear. Your signature indicates consent.

PATIENT'S RIGHTS

CONFIDENTIALITY All patient information is confidential and will not be released to anyone outside of the this practice except at the specific written request or authorization of the patient. Please be aware that if two or more adults are seen together, all must give written permission to release requested information. Phoenix HealthCare of Virginia complies with all Federal HIPAA regulations regarding protected health information. Please refer to the ***Notice of Privacy Practices*** for a detailed description.

TREATMENT Clients have the right to know the cost of services and treatment. You have the right to participate in the development of personalized service or treatment plan and the right to refuse recommended treatment and/or referral services. However, Phoenix reserves the right to terminate services in the context of a client's refusal to participate in recommended treatment.

PROFESSIONALISM Phoenix HealthCare of Virginia is dedicated to providing service that meets the highest standards of professionalism and ethical responsibility. You have the right to know the professional qualifications of your therapist and you are invited to inquire about her training or experience.

PATIENT'S RESPONSIBILITIES

TREATMENT Patients agree to participate in setting goals during therapy and in evaluating these goals as treatment progresses toward successful termination. Evaluation includes following through on agreed upon goals, and informing the therapist about progress made.

FEES Patients have the responsibility to pay fees according to the negotiated rate before each appointment. For some, medical insurance will pay part of the cost of therapy. Deductibles, co-payments and balances not covered by your insurance company are your responsibility. The current fee for 2017 is $120 per 45-50min session. Requests for professional letters are completed at the cost of $25/ 15 min. increments. Phone consultation is charged as a session fee, $120. SecureVideo conference is charged as a session fee, $120. In the event of a returned check there will be a fee of $25. Payment will then be due by credit card or cash. Discounts offered for local Sheriff Department and churches when office has been contacted by staff. In the event my account is referred to Commonwealth Financial Services for collections, I agree to pay all costs incurred in collecting the amount due, including an additional amount of 33.5 % as attorneys /commissions fees.

CANCELLATIONS Patients are responsible for setting and keeping scheduled appointments. You are responsible for notifying Phoenix HealthCare of Virginia 24 hours in advance if an appointment will be missed. If communication was NOT established within 24 hours a cancellation fee of fifty dollars [$50] for the missed appointment will be charged. Missed appointments with no phone call will be charged the hourly rate. If an emergency arises within 24 hours, communication is established and the session is rescheduled no fee will be charged for the first two consecutive occurrences.

COURT Phoenix HealthCare of Virginia does not provide forensic evaluation services. If you or an attorney subpoena a therapist for court testimony, you agree to pay the full clinical fee for the therapist's preparation, travel, waiting, and testifying time. These charges will apply even if the therapist is excused from testifying.

EMERGENCY CARE Phoenix HealthCare of Virginia is not an emergency service. In an emergency situation, if I cannot reach my therapist directly, I have been advised to contact my local community mental health center, family physician or local hospital emergency room. Emergency numbers available through the office.

I have read, understand, and agree with my rights and responsibilities as stated above. I also hereby acknowledge that I have received, reviewed and had an opportunity to ask questions about the **Notice of Privacy Practices** for Phoenix HealthCare of Virginia.

Signature_____ Date_____
Printed Name_____ Date_____
Therapist_____ Date_____