PsyCare, Inc., Custody Contract

(858) 279-1223/fax: (858) 279-8150/www.psycare.org

PSYCARE POLICIES REGARDING JOINT CUSTODY

1. PsyCare providers do not conduct custody evaluations or give custody opinions.
2. If parents have joint legal and medical custody, both must agree on the treatment plan for the children to be treated by PsyCare.
3. In court custody matters, children's records will be released only by an order by the judge or to an attorney appointed by the court to represent the child. In court matters, children own privilege to their records.
4. Records will not be given to parents. Such violation of confidentiality would destroy the therapeutic relationship.
5. All parents, even non-custodial parents have a right to know how the child is doing in therapy.
6. If adversarial conditions between the divorced parents are contaminating the child's therapy and causing the child additional guilt, anxiety, and stress, the PsyCare provider will recommend termination of therapy until the parents attend Parent's Turn, and/or the children attend Kid's Turn, a community service to aid children of divorce.
7. **Therapist reports:** A minimum fee of $50 will be charged for any letters, reports or treatment summaries requested by either custodial parent. **Physician reports:** The fee charged will be at the discretion of the physician. **Each custodial parent will be provided with a copy of the document. The requesting parent shall make payment for clinical documents(s) at the time of request.****

****Both parents must initial #7 _____Parent Initials _____Parent Initials**

COMPLETED BY BOTH PARENTS OF CHILD

Child's Name:_____ **DOB:**_____

I give my consent for my child to be treated by the following (check one box only):

☐ **MD only** ____/_____ (both parents initial) ☐ **Therapist only** _____/_____(both initial)

<OR> ☐ **MD and Therapist**_____/_____ (both initial)

***Note: Custodial parents must agree on level of care. In the event that one custodial parent revokes consent for treatment with a therapist or a psychiatrist (MD), each parent must sign a new PsyCare Custody Contract.**

A) Transportation will be arranged by the parent who the child is residing with on the date of scheduled appointment and/or agreed upon mutually between parents.

B) The parent scheduling the appointment will be responsible for canceling appointments within 24 hours and/or paying any associated late cancellation fees. Parents agree to communicate with each other when cancelling or rescheduling appointments.

C) Copays/Deductibles are to be paid at the time of session, please list only **one (1) parent** who will be financially responsible for all balances even if both parents are legally responsible for payment.

D) **PsyCare does NOT do mediation or get involved with parents financial arrangements.**

Name of financially responsible parent (**one name only**)_____

Address of financially responsible parent:_____DOB:_____

- **By signing below, I have read and agree to the above policies and to A through D.**

PARENT SIGNATURE:_____ Date:_____

Please print parent name:_____Cell Phone:_____

PARENT SIGNATURE:_____Date:_____

Please print parent name:_____Cell Phone:_____

Note: This custody contract AND pages 1 & 2 of "PsyCare's Welcome Packet" (found on our website) needs to be separately signed by both parents. Please ensure this contract and/or all paperwork is completed and signed by both parents prior to the child's appointment to avoid the child's appointment being rescheduled or cancelled. These policies are consistent with California State Laws.

Welcome to PsyCare, Inc.

(completed by patient or parent/legal guardian)

Patient Name_____ **File#:**_____

Welcome! We are happy to have you or your family member as a patient and will do everything within our professional capacity to make the treatment as productive as possible.

The specifics of the treatment goals and the steps to achieve these goals will be discussed at the first appointment. Your participation and understanding of the treatment goals are essential for the best benefit of therapy. If you ever have any questions about the nature of the treatment or anything else about the care, please do not hesitate to ask.

CONFIDENTIALITY and AUTHORIZATION TO RELEASE INFORMATION

It is understood that all information between patient and psychiatrist/therapist is held strictly confidential, and the psychiatrist/therapist will not release any information about therapy unless permitted by law or:

1. It is agreed upon in writing and complies with State Laws,
2. The patient presents an imminent danger to self,
3. The patient presents an imminent danger to others,
4. Child/elder abuse/neglect is suspected,
5. As necessary for continuity of care,
6. If a judge determines that our discussions are not confidential, a judge may request specific information,
7. As requested by a court appointed attorney for a child involved in court proceedings.

It is understood that in cases #2, #3 and #4, the psychiatrist/therapist is required by law to inform potential victims and legal authorities so that protective measures can be taken. If I participate in group counseling, I agree not to discuss any details of the group outside of the counseling sessions. PsyCare follows the 'minimum necessary" rule for release.

PATIENT CONSENT TO RELEASE OF INFORMATION

I consent to information release about my case (or my child's case) with the referral source and other co-treating health care providers and facilities for the purposes of treatment, payment and Health Care Operations. I further consent to the release of information to my health plan for claims, certification/case management/quality improvement and other health plan purposes.

GENERAL CONSENT FOR TREATMENT

I further authorize and request that my psychiatrist/therapist carry out psychological examinations, treatment, and/or diagnostic procedures that now or during the course of my care as a patient are advisable. I understand that the purpose of these procedures will be explained to me upon my request and subject to my agreement. I also understand that while the course of therapy is designed to be helpful, it may at times be difficult and uncomfortable.

GENERAL CONSENT FOR TREATMENT CHILD (If patient is a child or dependent of beneficiary)

On the patient's behalf, I (the legal Guardian or Legal Representative) authorize PsyCare to deliver mental health services to the patient. I understand that all policies stated on this page apply to the patient. **I accept that the child's records are confidential and that by law, I cannot have access to the child's records if such access would be detrimental to the child.**

CONSENT TO TREATMENT SIGNATURE

_____ _____ _____ _____

Patient/Legal Representative Signature Date **2nd Parent Custody Signature** Date

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION WITHIN THE PSYCARE SYSTEM

I authorize that PsyCare providers may disclose any information**, including Drug and Alcohol Abuse and HIV status**, regarding my (my child's) treatment for purposes of Continuity of Care within the PsyCare system only. Such a disclosure is only for the purposes of continuity of care within PsyCare, including between providers and to permit our various departments to aid in provision of services.

_____ _____ _____ _____

Patient/Legal Representative Signature Date **2nd Parent Custody Signature** Date

Welcome to PsyCare, Inc.

Patient Name_____ **File#:**_____

FINANCIAL TERMS

I understand that PsyCare is performing a courtesy for me by billing my insurance company and it is ultimately my responsibility to know my insurance benefits and coverage. Upon verification of health plan/insurance coverage and policy limits, my insurance carrier will be billed for me and my provider will be paid directly by the carrier. PsyCare will make every effort to assist me in getting my claims paid correctly, however, PsyCare may need to contact me to have me help resolve claim issues with my insurance company. **I will be responsible for any applicable deductibles and co-payments at the time of service. I agree to make these payments at each appointment.** I understand that I will incur a charge of $10 for any balance not paid and for every time PsyCare generates a bill for me. I do have the option of paying cash, due at time of service, and then billing my insurance company directly for reimbursement. I understand that if I am not eligible at the time services are rendered, I am responsible for payment, even if the determination is made after services are rendered. I understand the charge for a bounced check is $20.

THERE WILL BE A SERVICE CHARGE OF $10 FOR EACH STATEMENT GENERATED.

APPEALS AND GRIEVANCES

I acknowledge my right to request reconsideration in the case that outpatient care (number of visits) are denied certification (Appeal). I understand that I would request an Appeal through my Provider and that I risk nothing in exercising this right. I also acknowledge that I may submit a grievance to the Provider, Clinical Director, or Quality Management Team at any time to register a complaint about any aspect of my care. When appropriate, individual cases will be reviewed by the Medical Director. If I am not satisfied with the response I receive, I may submit the Grievance to my insurance directly.

EMERGENCY PROCEDURES

If you need to contact your provider, leave a message according to the instructions on the phone service and your call will be returned. If an emergency situation arises, follow the emergency procedures and/or inform the answering service that your call is an emergency. Please do this for true emergencies only. There may be a charge for telephone consultations that require 10 minutes or longer.

SATISFACTION SURVEYS, ASSESSMENTS

To maintain and enhance the quality of the services we provide, you will occasionally be asked to provide us with your input regarding the care you receive. We value your opinions and assure you all information is kept confidential. When you are asked to provide your thoughts during the course of your treatment, please provide us with your honest evaluation of the services you have received. We carefully consider all responses and make changes, when necessary, to provide enhanced services.

ZERO TOLERANCE FOR THREATENING/VIOLENT BEHAVIOR

PsyCare has a zero-tolerance policy for any threatening and/or violent behavior. If I exhibit any threatening and/or violent behavior, my care will be immediately terminated. _____ ***Patient's Initials***

CANCELLED/MISSED APPOINTMENTS & REQUEST FOR RELEASE OF RECORDS

In the event of a "No Show" or failure to give **a full 24-hour notice** of a cancellation, a **$75 charge will be assessed to all late cancellations and missed appointments.** If I sign to request my records to be released, there will be a $0.25/page fee for release of records (government agency requests are excluded), in addition to a $14 fee to retrieve older charts from storage where applicable. Charges will not exceed $30 total.

_____ / _____ ***Patient's Initials/2nd Custody Parent Initial***

I have received a copy of the "Patients Privacy Notice" and Patient's/Client's "Rights and Responsibilities".

_____ / _____ ***Patient's Initials/2nd Custody Parent Initial***

_____ _____

Patient/Legal Representative **Name**-*Please Print* Date

_____

Patient/Legal Representative **Signature**

_____ _____

If applicable, 2nd Parent Custody **Signature** and ***Please Print Name*** Date

_____ _____

Provider Signature and License # Date