HIRSCH PEDIATRICS
COUNSELING SERVICES
THERAPY CONSENT FORMS

____ (please initial) OVERVIEW AND LIMITS OF CARE

- Our goal of therapy is to provide targeted therapy to achieve immediate therapeutic goals on a timeline that is agreed upon by the patient and the therapist.
- Hirsch Pediatrics reserves the right to refer patients to other qualified therapists when the patient requires more frequent sessions or a longer duration of therapy.
- Therapy at Hirsch Pediatrics is only available to current patients of Hirsch Pediatrics.

____ (please initial) STRUCTURE OF APPOINTMENT

- Counseling sessions will generally last 45-50 minutes. Please try to arrive promptly since appointments must end on time to accommodate the next scheduled appointment.
- Counseling sessions may include the child and/or parent.

____ (please initial) TRANSFER OF CARE

- Hirsch Pediatrics reserves the right to refer patients to other qualified therapists in the following situations:
  - patient or family is not an active or willing participant in the therapy plan
  - patient is activity suicidal or has significant drug abuse
  - divorce with significant parent conflict that is disruptive to the therapeutic relationship
  - other therapy situations where for any reason the therapist is not able to achieve the agreed upon goals

____ (please initial) CONFIDENTIALITY

- In managing confidentiality concerns, the counseling staff will follow both the ***Ethical Principles of Psychologists and Code of Conduct*** from the American Psychological Association and **Maryland state law.**

- All mental health appointment interactions with Hirsch Pediatrics, including scheduling of or attendance at appointments, content of your sessions, progress in counseling, and your records are confidential. No record of counseling is contained in any academic, educational, or job placement file. You may request in writing that the counseling staff release specific information about your counseling to persons you designate outside of Hirsch Pediatrics.

____ (please initial) EXCEPTIONS TO CONFIDENTIALITY

- The counseling staff works as a team. Your therapist may consult with other counseling staff and staff at Hirsch Pediatrics to provide the best possible care. These consultations are for professional and training purposes.

- If there is evidence of clear and imminent danger of harm to self and/or others, a therapist is legally required to report this information to the authorities responsible for ensuring safety.

- Maryland state law requires that therapists who learn of, or strongly suspect, physical or sexual abuse or neglect of any person under 18 years of age must report this information to county child protection services.
- A court order, issued by a judge, may require that Hirsch Pediatrics release information contained in records and/or require a therapist to testify in a court hearing.

I have read and fully understand the above information and can discuss the above information with anyone on the therapy team. I understand the risks and benefits of counseling, the nature and limits of confidentiality, and what is expected of me as a recipient of therapy from Hirsch Pediatrics. I acknowledge that I received HIPAA consent forms as a patient of Hirsch Pediatrics and these forms also apply to therapy services.

____
Name of Patient(s)

____
Signature of Parent/Guardian
(if client is under 18 yrs old)

____
Signature of Therapist

____
Signature of Patient (if 16 yrs old or older)

____
Date

HIRSCH PEDIATRICS
COUNSELING SERVICES
FINANCIAL POLICIES AND PAYMENT CONSENT FORM

- Counseling services from Hirsch Pediatrics are billed directly to insurances for all in-network insurances. To verify that your insurance is in-network, please notify us before the appointment of any insurance changes. (Note: There are some insurances that may be in-network for appointments with Dr. Hirsch but out-of-network for appointments with the therapist.)
- Reduced fees for self-pay families or out-of-network insurances is available and will be collected at the time of the appointment. Contact our office for current appointment fees.
- Deductibles, copays and other charges may apply. Note: Depending on the insurance your copay may be a specialist copay (which is usually higher than a primary care copay), and you may have a separate mental health deductible/coinsurance.
- To ensure we can provide in-network therapy services to streamline the administrative functions Hirsch Pediatrics requires a credit card on file for payment of therapy related copays/deductibles and no-show fees (refer to no show policy form).
- Credit card information will only be stored encrypted with the payment processing company and will not be stored onsite at Hirsch Pediatrics.

By signing below I acknowledge that I have read the Hirsch Pediatrics Financial Policies and Payment Consent Form and will provide my credit card information BEFORE my first therapy session as well as ensure that my credit card information remains up-to-date.

____
Name of Patient(s)

______________________________	__________________________
Signature of Parent/Guardian (if client is under 18yrs old)	*Signature of Therapist*
______________________________	__________________________
Signature of Patient (if 16 yrs old or older)	*Date*

HIRSCH PEDIATRICS
MENTAL HEALTH SERVICES
MISSED/LATE APPOINTMENT POLICY

Please notify us as soon as possible by portal or phone if you need to reschedule. We require a 24-hour notice of cancellation to allow us to use the time for others.

FIRST NO SHOW THERAPY APPOINTMENT FEE:

$75

SECOND NO SHOW THERAPY APPOINTMENT FEE:

$150

THIRD NO SHOW THERAPY APPOINTMENT FEE:

$150 AND DISCHARGE FROM THERAPY

Since it is important that all therapy appointments have ample time to accomplish the session goals, patients that arrive more than 15 minutes late will have the appointment cancelled and be considered a missed appointment.

____
Name of Patient(s)

____
Signature of Parent/Guardian
(if client is under 18 yrs old)

____
Signature of Therapist

____
Signature of Patient (if 16 yrs old or older)

____
Date