# Doorways, LLC

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## OFFICE POLICIES AND TREATMENT CONSENT

**THE OFFICE POLICIES AND TREATMENT CONSENT LISTED BELOW ARE DESIGNED TO MAKE YOUR CARE WITH OUR PRACTICE MORE EFFICIENT. PLEASE ASK ANY QUESTIONS YOU MAY HAVE WHEN YOU READ THE POLICIES AND CONSENT. PLEASE INITIAL WHERE INDICATED AND SIGN YOUR NAME BELOW. UPON REQUEST, A COPY OF THIS DOCUMENT WILL BE PROVIDED FOR YOUR RECORDS.**

**Client name: _____ DOB: _____**

## READ COMPLETELY BEFORE SIGNING

### CONFIDENTIALITY

All communications and records created in professional treatment between patient and provider are confidential unless:

1. You authorize the release of information with your signature.
2. You present a physical danger to yourself or others (i.e. child/elder abuse or neglect is suspected). By law your provider is required to contact the potential victims and/or legal authorities.
3. Your provider is consulting with another licensed health provider involved in your care, or obtaining discreet, anonymous consultation with a colleague about your case.
4. If a judge issues a court order for client records.

**INITIAL _____**

### LEGAL GUARDIANSHIP OR CUSTODY

Legal guardians can be required to provide proof of documentation establishing that guardianship, and parents can be required to provide a copy of the most recent court order (decree, parenting plan) regarding legal custody. For shared custody cases we will need both parents to complete, sign & date the "Office Policies and Treatment Consent" Form.

**INITIAL _____**

### CONSENT FOR TREATMENT AND CONSULTATION

I authorize and request that *(Treating Provider's name)* _____ and/or employees or independent contractors of Doorways, LLC carry out behavioral health treatments, diagnostic procedures, and/or dietitian services which now or during the course of my care are advisable. I understand that the purpose of these procedures will be explained to me upon my request and are subject to my agreement. I understand that while the course of treatment is designed to be helpful, it may at times be difficult and uncomfortable. I have the right to participate in treatment decisions and to review my treatment plan with my provider. I also have the right to refuse any recommended treatment and to be advised of any consequences of refusal.

If I have questions or concerns and have not been seen in the office for over a month, I will schedule an appointment. If I have been seen within a month, I will leave a voice message at (602) 997-2880. My call will be returned within 1 business day.

For medication monitoring, I will need to see the Psychiatric Provider. There is a 72 hour turn-around time for prescription renewals. Prescriptions will not be refilled after 12 noon on Fridays, or on weekends.

Insurance coverage can have different medical and mental health benefits. It is my responsibility to know my benefits and coverage options. It is my responsibility to notify Doorways of any insurance changes if applicable.

**INITIAL _____**

### APPEALS AND GRIEVANCES

I have the right to register a complaint about any aspect of my care to the provider, insurance carrier, or relevant state association or board for any of Doorways providers. I may request a copy of the Grievance form at any time.

**INITIAL _____**

### RELEASE OF INFORMATION FOR INSURANCE

I authorize the release of information for claims, certification/case management/quality improvement and other purposes related to the benefits of my health insurance plan as applicable.

**INITIAL _____**

## TREATMENT PROVIDER DISCLOSURES

Please initial below signifying you understand that if you have any questions regarding treatment with the following providers, you may contact their supervisor (as listed below) at any time.

**INITIAL _____**

| Type of Licensure | Treating Providers | Clinical Supervisor & Contact Number: | |
|---|---|---|---|
| **Licensed Associate Counselor (LAC):** An LAC is a clinician that has met the educational requirements of a Master's degree, has completed a practicum and internship in counseling, and is licensed by the Arizona State Board of Behavioral Health Examiners. As part of their licensure requirements, a LAC must be supervised through their first 3200 hours of clinical practice. They will be reviewing all client related issues on a regular basis. | Abigail Jones | Marian Humphries, LPC | 602.997.2880 |
| | Aviya Bensky | Andy Schanen, LPC | 602.997.2880 |
| | Jason Klarer | Andy Schanen, LPC | 602.997.2880 |
| | Jenna Daniel | Marian Humphries, LPC | 602.997.2880 |
| | McCall Campbell | Andy Schanen, LPC | 602.997.2880 |
| | Tara Villars | Marian Humphries, LPC | 602.997.2880 |
| **Masters of Counseling (MC) Intern** | Clare Graff | Andy Schanen, LPC | 602.997.2880 |
| | David Russell | Marian Humphries, LPC | 602.997.2880 |
| | Jason Ellis | Marian Humphries, LPC | 602.997.2880 |
| | Madelyn (Maddie) McLean | Marian Humphries, LPC | 602.997.2880 |

## OFFICE SETTING, SCHEDULING, AND CORRESPONDENCE

- Please do not bring small children to your appointment as they will not be able to be supervised or watched in the waiting room while you are being seen.
- If you are more than 5 minutes late for your scheduled psychiatric appointment, you will need to reschedule the appointment and a cost will be incurred.
- If you are more than 15 minutes late for your scheduled counseling appointment, you will need to reschedule the appointment and a cost will be incurred.
- Counseling sessions with therapists vary between 45 to 53 minutes depending on your insurance plan.
- Please note all cancellations or rescheduling of appointments must be done with Doorways front office staff.
- **If an appointment is missed or cancelled with less than 24 business hours' notice, you will be charged $50 for the appointment. For Monday appointments, you are required to contact Doorways on the Saturday prior to your appointment in order to avoid any late cancellation or no show fees.**
- **After three "No Show" or late cancellation appointments occur, any additional previously scheduled appointments will be cancelled and not rescheduled until fees have been paid. Clients may be able to continue services on a same day only basis.**

**INITIAL _____**

I, furthermore, understand I am fully financially responsible for all patient charges resulting from treatment regardless of whether or not these services/charges are covered by my insurance plan. Please be aware some Diagnosis Codes are not covered by insurance. **Please be advised if outstanding invoices are turned over to Collections there will be a 30% fee assessed to the outstanding balance.**

**INITIAL _____**

I understand and agree to all the above.

_____

Patient Name (print) Patient Signature Date

_____

Parent/Guardian(s) Name (print) Parent/Guardian(s) Signature (s) Date

**INITIAL _____** *I am aware that I may request a copy of the Notice of Privacy Practices, list of Client Rights or Governing Agencies contact information, at any time.