



Consent to Treatment

I hereby authorize and give consent to the Nevada Center for Behavior Therapy, and its Psychologists to treat me. I understand that the financial obligation is my responsibility as the patient. I am responsible for any fees charges incurred, including those portions not paid for by my insurance carrier or by the provisions or policies of my benefit plan. If I have an insurance plan that provides coverage for mental health services and NVCBT treating staff is a network provider on the plan, it will cover a certain number of sessions. If I choose to see NVCBT treating staff, although they are not network providers for my plan, or if the service provided is not covered by my plan, I will be billed directly by NVCBT.

NVCBT treating staff will see me at the time scheduled. Because this time is reserved solely for me, it is important that I keep this appointment. NVCBT understands that circumstances may arise which necessitate the cancellation of occasional appointments. In these cases, I must give NVCBT treating staff at least 24 hours notice of any appointment I need to cancel. I understand that I will be charged for any missed appointment or appointments cancelled or broken **without** a 24 hour advance notice to NVCBT treating staff.

CONFIDENTIALITY: NVCBT treating staff will be keeping records on the services rendered. Should I wish to release any information to a third party, I will need to sign a consent and pay for copying your file. The material I discuss in therapy is personal and confidential. Nevertheless, NVCBT treating staff are required by law to make exceptions in certain specific situations. In those situations information may be shared **without my** consent. Those reasons are as follows:

- 1.) When NVCBT treating staff have reason to believe a patient presents a risk of immediate harm to himself/herself or to another person.
- 2.) When NVCBT treating staff know or have reasonable cause to believe that a child has been abused or neglected.
- 3.) If NVCBT treating staff know or have reasonable cause to believe that an older person has been abused, neglected, exploited, or isolated.



4.) When your records are subpoenaed by a court, I understand that once therapy begins, I retain the right to withdraw consent to participate in therapy at any time that seems appropriate. I will make every effort to discuss my concerns about the progress of therapy with NVCBT treating staff before I terminate treatment.

I have received a copy of the notice of privacy practices as required by the Health Insurance Portability and Accountability Act (HIPAA). I have read and understood the preceding statements. I am aware that if I have any questions regarding this consent and/or the notice of privacy practices either now or in the future, I may address them to NVCBT treating staff.

My signature below indicates that I agree to abide by the terms above and also serves as an acknowledgment that I have received the notice of privacy practices (HIPAA) form.

Signature of Patient _____

Date _____ Print Name _____