CONSENT AND AUTHORIZATION FOR TREATMENT

We at The Mauriello Group strive for client growth and improvement. It is our goal and desire to work with clients so that they may gain the capacity to resolve their own challenges. Together with your healthcare professional, we hope that you will feel confident that you are able to face both your immediate challenges and the ones you will face in the future. The needs of our clients vary greatly, but together, our team will work to help you close the distance between where you are today and goals you strive to reach. As such, treatment may only be for several sessions, while other treatment programs can run for months or years. Together, we will work to achieve the best possible results for you.

Client Agreement and Contract

I hereby authorize and voluntarily consent to professional counseling, social work, marriage & family therapy, psychological, psychiatric, medical, nursing, assessment, and/or other behavioral healthcare services from *Matthew J. Mauriello, MA, P.C.* (DBA "The Mauriello Group") as recommended by the professional(s) directly involved with my and/or my child's treatment as provided by _____, Pennsylvania license number _____. My signature below indicates the following:

- I have been informed of the recommended assessment and/or treatment services, including benefits and risks. I have also been informed of alternative assessments and/or treatments including potential risks and benefits from not receiving assessment and/or treatment services; I know some of these risks include having to experience uncomfortable feelings like sadness, anxiety, anger, or frustration because behavioral healthcare involves examining problematic thinking, discussing embarrassing or troubling behavior, or recalling unpleasant parts of one's history. I am also aware of and understand my rights as a client, including being offered a copy of my rights.
- I agree to participate in the development of the goals and objectives of my and/or my child's treatment plan and consent to said services. I understand that my agreement with my and/or my child's individual treatment plan will be indicated by my signature below. I understand that it is my right and responsibility to remain an active participant in any treatment plan changes.
- I understand that it is impossible to guarantee results regarding my treatment or assessment goals. I and/or my child will receive guidance to identify important issues, but it is up to me and/or my child to implement recommendations.
- I understand that standard counseling sessions are approximately 45 to 60 minutes in duration. I understand I am expected to be prompt with all scheduled sessions, giving no less than 24 business hours notice of a cancellation except for unpredictable emergencies. I understand the Cancelation Policy of *Matthew J. Mauriello, MA, P.C.* that reads I will be charged the full amount of the hourly rate listed below for any missed sessions. It is my responsibility to contact *Matthew J. Mauriello, MA, P.C.* and/or my assigned treatment provider(s) to cancel or reschedule appointments; a missed session(s) is grounds for termination from services.
- I understand that if I am dissatisfied with services, I will explicitly let it be known so any problem can be quickly resolved. I understand that I may terminate services at any point without consequence.
- I understand that in the event my assigned provider(s) becomes incapacitated or dies, it will become necessary for another provider to take possession of my and/or my child's file and records. By signing this form, I authorize and consent to allowing another appropriate healthcare professional selected by the assigned provider to take possession of my and/or my child's file and records to provide me with copies upon request, or to deliver them to a new healthcare provider of my choice.

Confidentiality of Client Information and Records

I understand that state law and professional standards require that healthcare providers create and maintain treatment records. I know that I am entitled to review, to request amendments, and to receive a copy of my and/or my child's records. I understand that because these are professional records they can be misinterpreted and/or upsetting; therefore, it would be best to review records in the presence of my assigned provider. I understand I will be charged an appropriate fee for any time used to prepare any information request from me or a third party.

I understand that all information pertaining to or arising out of the treatment and/or assessment of any client by *Matthew J. Mauriello, MA, P.C.* is considered confidential. We shall not use or release any information disclosed to us during assessment or treatment, or any information about a client's treatment or the services received, except with the written consent and authorization of the client or the client's parent or legal guardian, if the client is under the age of 14 years. I understand that only the minimal information needed to conduct treatment, payment, or healthcare operations activities will be used or released. I understand that exceptions exist to the above statement of confidentiality, whereby information may be released by us without my and/or my child's consent in accordance with state and federal law. These include, but are not necessarily limited to:

- Suspicion of abuse (either current or past) of children, elderly, or disabled. All behavioral healthcare providers, including those at *Matthew J. Mauriello, MA, P.C.*, are mandated reporters of suspected abuse.
- Indication of a client's risk and/or intent to harm self or others.
- Under court order.
- Any treatment, payment, and healthcare operations activities as defined in the HIPAA Privacy Rule under 45 CFR §164.501.

Communications Policy

I understand that *Matthew J. Mauriello, MA, P.C.* follows a Communications Policy that governs the use of any media used to contact me and/or my child. All electronic communications from my provider(s) employ encryption to protect my and/or or my child's confidentiality, and I will be given secure options to contact my provider. I understand that any treatment-related questions will not be addressed by my provider in any electronic communication, but will be addressed during the next scheduled appointment. Any electronic communications made by or sent to me and/or my child are retained in the logs of my digital providers (e.g., internet provider, e-mail provider, etc.); while it is unlikely that someone will access these logs, they could be read by the system administrator(s) of the digital providers or other third parties. I know that any e-mails or text messages and any responses will become part of my and/or my child's treatment record. I understand I also have the right to waive my right to secure communications for my convenience. I understand that my provider(s) does not accept requests to connect on any social media site from either current or former clients because these sites can compromise confidentiality, and can blur the boundaries of a professional relationship; I understand that any attempts to gain access to a provider's personal social media profile(s) will be cause for termination of services. I understand that my provider(s) will never solicit a testimonial from me, and I am urged to take their own privacy seriously when making any comments about services received online. I understand that my provider(s) do not as a regular part of practice search for information about current or former clients via online search platforms. I understand that my provider(s) may not be able to respond to messages and calls immediately; I can expect a response within 48 business hours.

Legal Issues

I understand that if I am involved in a legal issue (e.g., litigation, criminal investigation, custody matters, employment disputes, separation/divorce, etc.) that I will inform *Matthew J. Mauriello, MA, P.C.* immediately because it may affect the course of treatment. I am aware that in joint custody cases, signed permission from both parents and/or legal guardians is mandatory for a minor child to receive services. I am also aware that medical records (including behavioral health records) are frequently subpoenaed when legal issues emerge. I also understand if my provider(s) is called to testify, inevitable therapeutic harm could come as a result to me or my child. I further agree to compensate *Matthew J. Mauriello, MA, P.C.* at a rate of $200.00 per hour plus expenses if my provider(s) is subpoenaed by a third party or court-ordered be present at, to prepare statements (either verbal or written) for, or to offer any testimony on my or my child's behalf for any litigation with which I am involved. By signing this consent form below, I also agree that I will not make defamatory comments (either verbally or in writing) about *Matthew J. Mauriello, MA, P.C.* or its staff to others, or to post defamatory commentary on any website or social media site/outlet. In the event that defamatory remarks about *Matthew J. Mauriello, MA, P.C.* or its staff are made by me, or others acting in concert with me, I authorize and consent via my signature to allow *Matthew J. Mauriello, MA, P.C.* to release confidential information necessary to rebut, defend against, or prosecute claims for the defamation.

Payment Policy

I understand that *Matthew J. Mauriello, MA, P.C.* agrees to provide behavioral healthcare services for a monetary fee. The fee for each service is due at the time of the service. I am aware of and agree to the current fee schedule for all services offered by *Matthew J. Mauriello, MA, P.C.* If paying directly for services, the hourly rate is $150.00 for the 45- to 60-minute intake/diagnostic session. The hourly rate is $125.00 per 45- to 60-minute session hour for subsequent psychotherapy sessions. Either cash or checks are accepted forms of payment; please note that there will be a $25.00 fee for all returned checks. A receipt will be provided when requested. If I am paying for services directly, I may want to send a copy of a receipt to my insurance carrier(s) to request reimbursement for the service(s) rendered if my insurance is not already paying for the service(s). I agree (if permissible by law) to reimburse *Matthew J. Mauriello, MA, P.C.* for all costs, expenses, attorney fees, and/or legal fees that are incurred by *Matthew J. Mauriello, MA, P.C.* to collect outstanding balances. I further authorize and consent via my signature to allow *Matthew J. Mauriello, MA, P.C.* to release confidential information necessary to a third party (e.g., a collection agency) to secure payment for any outstanding balances.

Emergencies

I understand that providers at *Matthew J. Mauriello, MA, P.C.* provide outpatient, private practice behavioral healthcare services. It is unreasonable for my provider(s) to assume responsibility for clients' day-to-day functioning, as some more intensive treatment programs may do. It is my responsibility as the client to discuss expectations of after-hours care upon intake, if necessary, so appropriate plans can be agreed upon. In the case of an emergency, such as thoughts of hurting oneself or others, I agree to call 911 immediately and/or go to the nearest emergency room.

As the client and/or personal representative(s) of a client of *Matthew J. Mauriello, MA, P.C.*, the above information and policies have been fully explained to me. As the presenting legal guardian (if applicable), I have authority to consent to behavioral healthcare services for my child. I hereby authorize and consent to said treatment and/or assessment(s).

Printed Name of client	Signature of client (if age 14 or older)	Date
Printed name of personal representative	Personal Representative Signature (client under 18)	Date
Printed name of personal representative	Personal Representative Signature (client under 18)	Date
Printed Name of Healthcare Provider	Signature of Healthcare Provider	Date