DHA DAVID HOY & ASSOCIATES
Therapeutic Counseling | Change Your Mind

Client #:_____

Consent for Treatment

I voluntarily consent to evaluation, diagnostic testing, and/or therapy services provided by David Hoy & Associates clinical staff. I am aware that this agency trains therapists and an intern or trainee might be present in a session. This will be discussed with my provider and I can decline. I acknowledge that if there are multiple providers working on my case, they will be communicating and coordinating my treatment. I am aware that the practice of psychotherapy is not an exact science and that no guarantees have been made to me as to the result of evaluation or treatment in this program.

- ☐ I consent to telehealth therapy with my therapist from David Hoy & Associates. (Telehealth clients only)

Notice of Privacy Practices and Patient Bill of Rights

In compliance with HIPAA legislation, I have been provided an opportunity to review David Hoy & Associates Privacy Practices, and the Patient Bill of Rights.

Confidentiality

I understand that any assessments, tests, or inventories I may complete to be used in the course of my treatment are voluntary and will be kept confidential. If any information is used for research purposes, absolutely none of my personal information will be included in the research or any other documentation.

Insurance

I am responsible for providing David Hoy & Associates with insurance information that is complete and current. I consent to the release of clinical or other information necessary to an insurance company or 3rd party payer for purposes of payment as indicated by MN law. I authorize payment of insurance or 3rd party medical benefits to David Hoy & Associates for services rendered.

Cancellation of Appointments

I understand that I must give the provider a 24 hour notice of any cancelled appointments. If I fail to keep my scheduled appointments, I may not receive future services.

Financial Policy

When I receive services from David Hoy & Associates, I undertake a personal obligation and responsibility for my account. I am responsible for knowing my insurance benefits. I understand that it is my responsibility to provide David Hoy & Associates with current and complete information. I will pay all co-pays, co-insurance and deductibles owed to David Hoy & Associates as documented in the Explanation of Benefits (EOB) provided by my insurance company.

Email or Texting

I understand that David Hoy & Associates email, as well as texting, is not secure, therefore, should I choose to use either of these options to communicate with David Hoy & Associates it is voluntary and at my own risk. I understand that should I choose to email or text David Hoy & Associates, it is in my best interest to abstain from including personal or private information.

- ☐ I consent to send/receive text messages
- ☐ I consent to send/receive email

BY CONSENTING TO TREATMENT AND SIGNING THIS FORM, I AM AGREEING TO THESE POLICIES.

Client Name:_____ Client Date of Birth:_____

_____

Client Signature Date

_____

Provider Signature Date