Coordination of Care

Coordination of care among healthcare providers improves quality of care and achievement of treatment goals. Authorizing this coordination of care with your primary care provider (PCP) or another professional is optional though, increasingly, insurance companies are requiring this and considering this standard of care. If you authorize coordination of care with your PCP, Counseling Associates will send a confirmation to your provider that we have met for this initial session. Coordination of care may also include brief periodic updates regarding treatment and other coordination communications either in writing or by phone. We are happy to answer any questions you may have about coordination of care and this authorization.

☐ I authorize coordination of care between my PCP and Counseling Associates.
Please sign release on following page.

☐ I decline coordination of care at this time. *Do not complete release on following page.*

☐ I have questions about coordination of care and would like to wait and speak with my therapist.

☐ I have other providers or individuals for whom I would like to authorize communlcations.
Please sign release on following page and access additional forms at (website)

Consent to Treatment

I acknowledge that I have received, have read (or have had read to me), and understand the following (available on our website or in office):

- Counseling Associates Practice Information
- CA Cancellation Policy
- Notification of Privacy Policies Regarding Protected Health Information (PHI)
- Telebehavorial Health Informed Consent
- NH Mental Health Bill of Rights

I understand the information about the therapy I am considering. I have had all of my questions answered to my satisfaction.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist and that, as with any treatment, there are some risks as well as many benefits with therapy. I am aware that I may stop my treatment with this therapist at any time. I understand that I will still be responsible for paying for services already received. I understand that there may be consequences to such a decision outside of my therapist's control. (e.g. if my treatment has been court-ordered, I will have to respond to the court).

My signature below indicates that I understand the information about the therapy I am considering, and I have had all questions answered to my satisfaction. I agree to abide by the terms outlined throughout our professional relationship with Counseling Associates of New London, PLLC, which includes Counseling Associates of New London, Newport, Claremont, and the Upper Valley. I consent to receive services from Counseling Associates and I agree to take an active role in my treatment.

Signature of Client Date

Printed name