

CONSENT TO TREATMENT AND CLIENT RIGHTS DOCUMENT

The topics discussed in therapy will not be disclosed without permission of the client(s). If you wish to have information shared with another party, you will be asked to sign a Release Form to do so. However, there are three exceptions to this policy as mandated by law:

1. Child or elder abuse is disclosed.
2. Believable threat that client will attempt to harm self.
3. Believable threat that client will attempt harm to others.

In addition, if you have a medical emergency and "911" is called, it will also be necessary to release information as follows: your name, birthdate, emergency contact, insurance information, known medical conditions, known medications, and any use of alcohol or street drugs.

Payment of co-payments is requested at time of service. The client is responsible for payment of all balances, including any services not covered by a managed care plan. Cash, Credit, Debit Cards and Checks are accepted as payment. Co-payments requested are an estimate until a claim has been received.

Insurance claims will be filed on behalf of the client. The client is ultimately responsible for costs incurred and agrees to pay those costs. Benefit quotes are an estimate and not a guarantee of benefits.

A twenty four (24) hour notice is required for any cancellations. Clients will be billed for sessions cancelled with a twenty four (24) hour notice. Clients will also be billed for sessions missed without cancellation. If you are paying cash for your appointments, you will be billed forty dollars (\$40.00) if you do not provide twenty four (24) hours' notice. Payment must be made at your next appointment.

I have read the information above and understand this information.

Signed: _____

Date: _____

Signed: _____

Date: _____