The Center for Counseling
Your Life Is Precious.℠

Informed Consent for Treatment

1. I voluntarily consent to participate in the initial intake, assessment process and ongoing treatment.
2. I have been given the opportunity for discussion of any concerns that I have regarding treatment or any risks that may be involved.
3. I will be informed and take part in my treatment and goal planning and any reasonable alternatives and risks involved in not receiving proposed care.
4. I understand:
   a. that I may withdraw my consent in writing at any time and have expected consequences explained.
   b. that I must notify The Center for Counseling if my insurance carrier or coverage changes.
   c. I am responsible for monitoring my insurance. It is my responsibility to ensure participation and non-participation. I am responsible for payment of any services not covered by insurance and will pay any and all charges, co-pays, and deductibles owing The Center for Counseling in accordance with their regular rates. Any insurance balance not paid within 120 days will become my responsibility, The Center for Counseling will provide receipts so that I may turn them into insurance company.
   d. Any and all balances will need to be paid off at the time of appointment. Next appointments can not be made until balances are paid.
   e. That if I must cancel an appointment, I am required to contact the office 24 hours prior to the appointment. Voice mail is available 24 hours a day, 7 days a week. <u>If I fail to contact the office, I will be charged at the rate $45 NO EXCEPTIONS!!</u> This fee is **not** billable to your insurance, and is due at the beginning of the next session. _____**.** That if I am a late cancellation or no call no show twice in a one year period my case will be closed.
   f. Balances over 30 days will accrue a service charge of 1.5% monthly, 18% annually. In addition to the above service charge, I agree to pay all costs of collection, including filing fees, court costs , and reasonable attorney fees.
   g. That I will be charged $25 for any non-sufficient funds checks.
   h. That in case of inclement weather, I am to call the office prior to my appointment to confirm that the CFC is open. If we have closed, there will be a message on our recording indicating the closure.
   i. That if my therapist or physician must write letters or fill out insurance forms there will be a $35-$75 charge for this service and that it takes up to a week to complete.
   j. That my medication reviews are scheduled so that there is no lapse in medication. If I must have a prescription written or called into my pharmacy there is a $10 office fee for this service.
5. I have read and received a copy of the fire evacuation, fire drill procedure, tornado warning drill procedure and building map.
6. The Center for Counseling will use and disclose personal health information to treat you, to receive payment for the care we provide. We have prepared a detailed NOTICE OF PRIVACY PRACTICES BROCHURE to help you better understand our policies in regards to your personal health information. The terms of the notice may change with time and we will always post the current notices in our office, on our web-site and have copies available for distribution. I have received a copy of the Notice of Privacy Practices.

_____ _____
Client/Guardian Signature Date

_____ _____
Clinician Signature Date