Consent for Treatment:

I consent to assessment, treatment, and/or diagnostic procedures for myself or for my family member. I understand that the purpose of these procedures will be explained to me upon my request and subject to my agreement. I authorize the release and exchange of information between my therapist and the referral source and other co-treating providers and administrative staff for the purpose of treatment, payment, and Health Care Operations. I also authorize the release of information to my health plan for claims or other health plan purposes. I understand that I have a right to revoke this consent in writing at any time. I understand that this revocation will not apply to information already used or disclosed on the basis of my prior written consent.

Initials_____

HIPAA and client Rights:

I have read and received a copy of HIPPA privacy policies and a copy of client's rights.

Initials_____

Confidentiality:

All information disclosed within sessions or consultations is held strictly confidential and may not be revealed to anyone without a written release of information, except where disclosure is permitted or required by law. Disclosure is required in the following circumstances:

1. When there is a reasonable suspicion of dependent adult or child abuse or neglect.
2. When client presents an imminent danger to self or others.
3. If a judge determines that our discussions are not confidential, a judge may request specific information.

Initials_____

Fee Agreement:

Fees & Insurance: If you elect to pay out-of-pocket fees for services rendered, the rate is $150 per evaluation session and $100 per counseling session. Students have a discounted rate of $140 per assessment and $90 per session. All sessions are 60 minutes in length unless otherwise indicated. There will be a $25 fee for any returned checks.

Initials: _____

Clients who carry insurance should remember that professional services are rendered and charged to the client and not to the insurance companies. Please be aware that not all issues/problems/conditions dealt with in therapy are covered by insurance. It is your responsibility to verify the specifics of your coverage. If you are using insurance, I will submit claims for you. You are responsible for any applicable deductibles and co-pays at the beginning of each session. You understand that insurance is billed as a courtesy to you and that you are responsible for full payment if the insurance company denies the claim.

Initials: _____

Therapist under supervision:
I understand that my therapist is currently under the clinical supervision of ____Traci Cahill LPCC- S E.1100011 SPV ____Cindy Herzberg LPCC-S E.0800238 in the state of Ohio. All records are accessible to my supervisor. All of my clinical documents will be reviewed and signed by my supervisor.

Initials: _____

Right to Collect Payment:

I understand that my counselor reserves the right to submit my account to a collection agency in the event that my account is 90 days past due, unless other financial arrangements have been made between my counselor and myself. This may necessitate the release of personal information such as name, address, phone number, the amount of the outstanding balance, and any other information necessary to collect fees. I hold my counselor harmless for any adverse consequences that may derive from assignment of my account to a collection agency. I am also aware that in the event that my account goes into collections, there will be a 35% collection fee added to my account balance.

Initials: _____

Therapy Process and Termination:

Psychotherapy can result in a number of benefits to you, including improved relationships and a reduction in psychological symptoms. The process of talking about painful memories, thoughts, and feelings, however, can be difficult and can make clients feel worse for a time. Please discuss this with your counselor if you are feeling worse. There is no guarantee that therapy will yield positive or intended results. You are free to terminate therapy at any time. If you do stop coming to counseling, we will close your case after 2 months of no contact. You are welcome to resume counseling at any time.

Initials_____

Phone and Emergency Contact

If you need to contact your counselor by phone, please do so at the phone number provided to you by your counselor. If your counselor is not available, please leave a message and your call will usually be returned within 24 hours. If you cannot reach your counselor in an emergency situation, you can find help at the following suicide prevention/crisis locations: Netcare Access, which is open 24hours/7 days a week and no appointment needed at 614-274-9500. You can also call the Suicide Prevention Hotline available 24/7 if you need support- 614-221-5445.

Initials_____

Cancellation of Appointment

The scheduling of an appointment involves the reservations of time specifically for you. Please notify your counselor at least 24 hours in advance when you need to cancel or reschedule your appointment. Otherwise a $75 fee is charged except in the cases of extreme emergency. Please be aware that continued missed appointments, without notice, may lead to termination of services.

Initials: _____

Paperwork and Documentation Requests

I understand that it is at the discretion of my counselor to decide whether they will complete requested paperwork on my behalf. Paperwork including but not limited to Social Security disability, FMLA, short-term and long-term disability forms. I understand that there may be a document fee for any records requested by you or on your behalf at a billing rate of $100 per hour with 15 minute billable increments.

Initials: _____

By signing this I agree with the policies above.

_____

Print Client Name (parent/guardian if client is minor)

_____ _____

Client/Legal Representative Signature Date