Consent to Treatment

I _____, the undersigned, hereby attest that I have voluntarily entered into treatment, or give my consent for the minor or person under my legal guardianship mentioned above, at Renewed Hope Counseling Center.

I do hereby seek and consent to take part in the treatment by the therapist named below. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.

I am aware that I may stop my treatment with this therapist at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.)

I agree to pay the clinic fee of **85.00 per session** unless I qualify for the **financial assistance program** sliding scale rate. I understand that if payment for the services I receive here is not made, the therapist may stop my treatment.

I know that I must call **to cancel an appointment at least 24** hours before the time of the appointment. If I do not cancel with at least 24 hour notice, **I will be charged the full session amount for that appointment if on sliding scale. If I pay with insurance or pay the full clinic fee of 85.00 I will pay 75.00 for the missed appointment.** Insurance companies will not pay for missed appointment fees and must be paid by the client. The clinic director may waive this fee after the situation has been examined and the reason for cancelation deemed reasonable.

If I choose to submit payment record to my insurance company for out of network reimbursement I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), diagnosis code and providers of any services or treatments I receive

My signature below shows that I understand and agree with all of these statements.

_____ _____

Signature of client (or person acting for client) Date

_____ _____

Printed name Relationship to client (if necessary)

I, the therapist, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____

Signature of therapist Date

❑ Copy accepted by client ❑ Copy kept by therapist

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.