CONSENT FOR TREATMENT

I, _____ with full knowledge of the benefits and consequences of psychotherapy consent to be treated by _____ on a voluntary basis.

I also agree to take financial responsibility for my sessions at the rate of $_____ per 45-50 minute hour. I will pay for services at the time they are rendered or in advance. I realize that failure to pay for any given session will require me to send payment in by mail before the next session or it will not be conducted. Payment may be made by cash, major credit card or check, however, if a check is returned by the bank, you will be charged a $40 fee and denied the right to write checks as payment for your sessions.

Please be aware that you must give 24-hours notice for cancellations or be charged the full fee. You will also be charged for missing more than one session in a 30-day period unless you have scheduled this with the therapist in advance.

Excessive cancellations or requests for appointment time changes are disruptive to the therapeutic process, as well as the therapist's schedule. Should this become a concern, the therapist reserves the right to terminate treatment or assess a $40.00 re-scheduling fee.

If you plan to use your health insurance benefits, please be aware that it is your responsibility to inquire about mental health coverage and applicable deductions. All sessions must be paid for at the time they are rendered. You will be responsible for filing the claim and the insurance company will reimburse you. The therapist will provide you with all necessary information. It is illegal to bill an insurance company for missed sessions, please be informed that you are responsible for paying the therapist directly if this occurs.

Please make payments out to **Counseling Network, Inc.** Also, <u>please write your checks prior to your sessions</u>, not during or after – *thank you*.

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My signature below is binding to this consent and also indicates I have read, understand and agree to the policy above as well as agree to abide by them

_____

Signature of client Date

_____

Signature of therapist Date

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