CONSENT TO TREAT

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I consent to the outpatient psychotherapeutic evaluation and treatment recommended by Sara Cole, MS, LPC, CAC III. I am aware that psychotherapy is not an exact science, and that no guarantees have been made regarding the results of treatment.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client/Guardian Signature Date

FEE AGREEMENT

Please Initial the following box:

Self-Pay: \_\_\_\_ I agree to be responsible for the payment at the time of each 45 minute session in the amount of \_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Insurance:\_\_\_\_ I have \_\_\_\_\_\_\_\_\_\_\_ insurance and agree to be responsible for my co-payment and/or detectable (if applicable) at the time of each 45 minute session in the amount of \_\_\_\_\_\_\_\_\_\_\_.

EAP\_\_\_\_\_ I am using an EAP which is \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and have been authorized \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ sessions.

I agree to be responsible for each payment in the full amount for any missed appointment or appointment that was not cancelled within 24 hour notice.

* Credit card number on file: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EXP:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CVV\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I agree that if my check does not clear the bank I will be responsible for an additional $35.00. I authorize payments of medical benefits to the undersigned physician or supplier for therapeutic services. I accept assignment of benefit to Sara Cole, MS, LPC, CAC III.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client/Guardian Signature Date