**LORA HOFFSTETTER & COUNSELING ASSOCIATES, LLC**

**CONSENT FOR TREATMENT - PROFESSIONAL SERVICES AGREEMENT**

**RELATIONSHIP**

I understand that the effectiveness of psychotherapy depends on the efforts of the client as well as the practitioner, and I promise to make my best effort to comply with those procedures. I understand that I am entering into a therapeutic relationship with a licensed professional. I understand that this professional may recommend that I complete other forms of treatment; i.e.; psychological testing, psychiatric evaluation, or clinical homework. I understand that I am fully responsible for the outcome of my treatment, and that results may vary based on adherence to such recommendations. I further understand that Lora Hoffstetter & Counseling Associates, LLC (LHCA) is making no guarantees about the outcome of treatment, as the field of psychotherapy is based on individual response. \_\_\_\_\_\_\_ (Initial)

**CANCELLATION POLICY**

I understand that regular attendance will provide the maximum benefits but that I am free to discontinue treatment at any time. If I decide to do so, I will notify Clinician at least two weeks in advance so that effective planning for my continued care can be implemented. I agree to notify Clinician at least 24 hours in advance if I will be unable to attend any session. I understand that if I fail to make such notification, I may be charged a $75.00 cancellation fee which will not be reimbursed by my insurance company and I will be solely responsible for these charges. I also understand that I can call the office 24 hours/7 days a week to leave a voice mail message to cancel an appointment. Additionally, if I have three same day cancellations or no- show appointments, my therapist may decide to discontinue our sessions, and will refer me to a different facility. \_\_\_\_\_\_\_ (Initial)

**CONFIDENTIALITY POLICY**

I understand that conversations with the Clinician will almost always be confidential. I further understand that a mental health professional, by law, must report actual or suspected child abuse or neglect or elder abuse or neglect to the appropriate authorities. In addition, the Clinician has the legal responsibility to protect anyone that I may threaten with violence, harmful or dangerous actions (including those to myself) and may break confidentiality of our communication if such a situation arises. I understand that the mental health professional will make reasonable efforts to resolve these situations before breaking confidentiality. \_\_\_\_\_\_\_ (Initial)

**APPOINTMENTS FOR MINORS**

At least one biological parent or legal guardian must attend the first session with a minor client and present a photo ID. LHCA is ethically bound to verify the minor’s parent/guardian, so we will need to match signatures on ID to those on the new client paperwork. \_\_\_\_\_\_\_\_ (Initial)

**REQUESTS FOR COMPLETING FORMS/RELEASE OF INFORMATION TO THIRD PARTIES**

A flat fee of $20.00 will be charged for any forms that a client asks the clinician to complete, such as SSA, Disability papers, FMLA or leave of absence forms. Additional fees may be billed for extra services, including treatment or case summaries and reports, court related proceedings, and phone calls lasting more than 10 minutes (including coordination of care with other professionals and phone calls to clients directly). INSURANCE DOES NOT PAY FOR EXTRA TIME SPENT IN BETWEEN SESSIONS. *AN HOURLY FEE WILL BE PRORATED BASED UPON THE SERVICES RENDERED; Psychotherapist fee (LISW, LPCC, LSW, LPC, MFT) is $120.00 \_\_\_\_\_\_\_\_* (Initial)

**REQUESTS TO RELEASE CLIENT RECORDS**

If a client or an organization acting on the client’s behalf is requesting medical records, the request must be in writing and must be acted on within 30 days. If the provider believes that allowing a client access to his or her records may in any way be harmful to the client or someone else, access can be denied. Provider can also withhold records in non-emergency situations if client has a balance on their account. There will be a charge of 50 cents per page to print and send records. It is the clients’ responsibility to pay for any extra services. \_\_\_\_\_\_ (Initial)

**ASSIGNMENT & RELEASE: I HEREBY ASSIGN MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO LORA HOFFSTETTER & COUNSELING ASSOCIATES, LLC. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY NONCOVERED SERVICES, CO-PAYS & DEDUCTIBLES. I ALSO AUTHORIZE LORA HOFFSTETTER AND COUNSELING ASSOCIATES, LLC TO RELEASE ANY INFORMATION REQUESTED TO MY INSURANCE COMPANY, MANAGED CARE COMPANY, THIRD PARTY ADMINISTRATOR OR ANY OTHER PERSON OR ORGANIZATION NECESSARY IN THE SUBMISSION, PROCESSING AND APPROVAL OF CLAIMS. MY SIGNATURE BELOW INDICATES THAT I HAVE AGREED TO ALL THE ABOVE TERMS OF THIS CONSENT FOR TREATMENT/PROFESSIONAL SERVICES.**

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**CLIENT / PARENT OR GUARDIAN’S SIGNATURE DATE**

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**WITNESS SIGNATURE DATE**

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**CLINICIAN’S SIGNATURE DATE**