

CONSENT TO TREATMENT

I\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Print Name)

Have been informed of my rights and responsibilities as a client of Berenewed Counseling. This includes information about the nature and methodology of treatment, confidentiality, and about the criteria for termination of treatment.

I have been informed of my counseling fee, late fees ($50.00 for late cancel or no show) and of the payment schedule.

I have been informed that my insurance company will be billed if applicable. I am responsible for any payments that my insurance company will not cover, including deductible, co-pays, co-insurance or other fees under my insurance policy. I understand it is my responsibility to contact my insurance company to understand any or all fees that I am subjected to according to my policy.

I have received a copy of Berenewed Counseling’s Notice of Privacy Practices.

I am aware that I will not be derived of any of my civil rights while in counseling at Berenewed Counseling, nor will I be discriminated against. I understand that I have the right to review my records, discuss, and amend the information contained in it.

I understand that I am entitled to a copy of any consent form that I sign.

I hereby consent to treatment, to counseling fees and billing of my insurance company.

Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Therapist Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 04/15