Consent for Treatment

Prepared by Northwest Counseling, PLLC 4175 3 Mile Rd. NW, Walker, MI 49534

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Name ____Date of Birth:_________________ Date:_________________

Address/City/Zip____Home Phone____________________

Work Phone _____________________Work hours_________________ OK to call home?___ OK to call work?_______

Your attendance in any treatment program is voluntary. You may end treatment or refuse services at any time. You are encouraged to participate in developing your treatment goals. If you have concerns, complaints, or suggestions about services, you are encouraged to speak with your therapist about them.

PAYMENTS & INSURANCE REIMBURSEMENT: ***Payment of fees to be made at each visit unless arranged otherwise.*** You are responsible for all fees not reimbursed through insurance. If your account balance becomes severely delinquent without any activity you will have 10 days from your "final notice" to make a payment, or your account will be referred out to a State Licensed Collection Firm.

CANCELLATION: *Scheduling of an appointment means time has been reserved specifically for you. If you fail to cancel within 24 hours or if you miss an appointment, you will be charged your full therapy fee or $40, whichever is less. If you miss two appointments services will be terminated.*

CONFIDENTIALITY: Information in your therapy sessions and the written records of those sessions are confidential and may only be revealed ***without your written permission*** under the following circumstances: 1) when child, dependent or elder abuse or neglect is suspected; 2) by a formal court order; 3) when your therapist believes you are in danger of harming yourself or someone else; 4) if you have a medical emergency while at our office; 5) if we believe you have committed, threatened to commit, or are about to commit a crime at our facility.

Health Insurance & confidentiality of records: Your therapist may be required to give information about you to your insurance carrier in order to process claims.

Litigation Limitation: Due to the confidential nature of your therapy, *it is this therapist's policy not to appear as a witness in court without a court subpoena.*

Consultation: Your therapist consults regularly with other professionals regarding his/her clients; however, client name or other identifying information is never mentioned and confidentiality is fully maintained.

Your Right to Review Records: You have the right to review your records at any time, except in limited legal or emergency circumstances. When your therapist assesses that releasing such information might be harmful in any way, he or she will provide the records to an appropriate and legitimate mental health professional of your choice.

SUBSTANCE USE: If you arrive at our office under the influence of alcohol, illegal drugs, or prescription medication not prescribed for you, we will end the therapy session, charge for you for a missed appointment and ask you to leave the premises. We will also notify the Walker police if we believe you to be driving under the influence.

COMPLAINTS: All therapists pledge to follow professional and ethical standards. If you believe your confidentiality has been broken, or that any of your other rights have been violated, please discuss this with your therapist.

INVOLUNTARY TERMINATION: On rare occasions, we may ask that a client end services here. This can occur for behaviors including, but not limited to drug or alcohol abuse, or possession while at this agency; chronic missed appointments; a long-overdue bill; threats or actual crime against building personnel or property; unwillingness to cooperate in setting goals.

I acknowledge that I have been offered a copy of the "Notice of Privacy Practices" for NWC.___________
I acknowledge that I understand and have received a copy of NWC Fee Schedule.____________________

You may ask your therapist to explain further anything on this form. You may ask your therapist for a copy of this form.
I have read the above Consent for Treatment. I will comply with the terms and policies stated.

Client Signature____**Date**__________________________

WitnessSignature____**Date**__________________________