HOPE and HEALING of PINELLAS

Consent to Treatment

I acknowledge that I have received, have read (or have had read to me), and understand the "Information for Clients" brochure and/or other information about the therapy I am considering. I have had all my questions answered fully.

I do hereby seek and consent to take part in the treatment by the therapist named below. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.
I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.
I am aware that I may stop my treatment with this therapist at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.)

I know that I must call to cancel an appointment at least 24 hours before the time of the appointment. If I do not cancel, I will be charged my normal session fee for that appointment. For clients using insurance or EAP's, you will be responsible for paying the amount your insurance would reimburse the provider. This amount can be provided to you at your request. My Insurance will reimburse $_____ per session. This is the amount I pay In the event of a cancellation with less than 24 hours' notice. Initials_____

For convenience, I can provide a credit card to be charged for an appointment cancelled with less than 24 hours' notice. I authorize the provider to charge this card. Initials_____
Card number_____
Expiration_____
CVV (3 digits on back of card)_____
Billing zip code_____
If I do not provide credit card information, I am aware no further appointments will be scheduled until balance is paid. Initials_____

If cancellations become excessive (exceeding 3), my case may be closed and I will be provided with referrals to other providers if desired. Initials_____

I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive. I understand that if payment for the services I receive here is not made, the therapist may stop my treatment.

My signature below shows that I understand and agree with these statements.

_____ _____
Signature of client (or person acting for client) Date

_____ _____
Printed name Relationship to client (if necessary)

I, the therapist, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____
Signature of therapist Date