Consent to Treatment/Fee Agreement

I, _____ (hereinafter referred to as CLIENT), request the professional counseling services of _____ (hereinafter referred to as THERAPIST). In requesting these services, CLIENT understands that THERAPIST operates his/her practice individually, separately and apart from other mental health professionals sharing office space with him/her; the other mental health professionals have no responsibility or liability for CLIENT's treatment unless CLIENT requests their services and signs a treatment agreement with them.

Psychotherapy has both benefits and risks; CLIENT may get worse before getting better. However, the profit can outweigh the costs; psychotherapy has been proven to have significant benefits both physically and mentally. CLIENT is encouraged to ask questions and offer ideas throughout their treatment.

Emergencies
THERAPIST listed above is available by appointment only and will make every effort to return CLIENT's call as soon as possible (with the exception of weekends and holidays.) If CLIENT is receiving care when THERAPIST is out of town, THERAPIST will, if needed, provide CLEINT the name of a colleague to contact. In the case of an emergency and/or when THERAPIST is not available, CLIENT is urged to call 911 or contact Avera Behavioral or Sanford Hospital.

Communication
THERAPIST's preferred method of scheduling is by phone, however, scheduling via text message or email may be offered on an individual basis. If THERAPIST is not available to receive your call, phone messages will be returned within 12 hours (with the exception of weekends and holidays). If your THERAPIST chooses to offer scheduling via text or email, they will be responded to as thus: text messages within 24 hours, emails within 48 hours (with the exception of weekends and holidays). While our systems are encrypted to protect confidentiality, information shared via text or email should pertain to scheduling only.
Contact via social media applications is not an appropriate means for CLIENT to communicate with THERAPIST, therefore THERAPIST will NOT respond to any messages, requests or connections initiated in this manner.

Confidentiality
In general, the law protects the confidentiality between CLIENT and THERAPIST. However, the following exceptions may occur:

1) *CLIENT authorizes the release of information with a signature.*
2) *THERAPIST is ordered by the court to release information.*
3) *CLIENT presents a physical danger to self or others or has intent to commit a crime.*
4) *There is evidence or reasonable suspicion of child/elder abuse and/or neglect.*

Financial Agreement
Payment is due at the time of service which may include CLIENT's full fee or co-pay associated with CLIENT's insurance company. This office will provide necessary information to your

insurance company and attempt to collect payment; however, CLIENT is ultimately responsible for payment of CLIENT's account.

A scheduled appointment is a time that has been specifically reserved for the CLIENT; should CLIENT need to cancel his/her appointment, 24 HOUR NOTICE IS REQUIRED. Should CLIENT fail to provide adequate notice of cancellation, THERAPIST will allow two exceptions as a courtesy to CLIENT. However, a missed session fee of $50 per session will be billed to the client for subsequent missed sessions. Should CLIENT need to reschedule his/her appointment due to illness or inclement weather, CLIENT should contact THERAPIST as soon as possible to arrange for an alternate appointment time.

Counseling sessions are typically 45-50 minutes long. While each CLIENT's insurance company dictates allowances and payment levels, the breakdown includes:

- Your fee per session is $_____
- Your insurance company is expected to pay $_____ per session
- You have a deductible of $_____ which has/has not been met.
- Your payment or co-payment will be $_____ per session.

If you are unsure of the particulars of your insurance coverage, you can learn more by referring to your policy booklet or by calling the toll-free number listed on your insurance card.

In regards to CLIENT's rights, CLIENT as the consumer has the right to fair and professional treatment; all HIPAA regulations apply to this office. CLIENT acknowledges that he/she has been provided a copy of this office's Notice of Privacy Practices by initialing here ☐

CLIENT has been given the opportunity to ask questions which have been answered to their satisfaction. CLIENT has read the above and has had the opportunity to discuss this information and any questions with THERAPIST. CLIENT also confirms that the information they have provided THERAPIST for their treatment is current and accurate.

CLIENT completely understands his/her rights, his/her consent to treatment, and agrees to pay the per-hour rate contained in this agreement and accepts his/her responsibilities as stated above.

CLIENT Signature Date

Completed and Witnessed by Date

Parent/Legal Guardian (if CLIENT is a minor) Date