Center for Life Solutions

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Welcome to our practice! Please read the following policies and sign this consent form to indicate your acceptance of the terms of treatment. (Please place checkmark next to each paragraph, indicating you're in agreement with terms).

___Consent to Treatment: Assignment of Insurance Benefits. I authorize the Center for Life Solutions to furnish information regarding services rendered to me or my minor child as needed to bill my insurance under the terms of my contract. I further authorize the Center for Life Solutions to supply limited and protected health information (PHI) to their billing service, for the purpose of billing and collection. If I am a managed care client, it is my obligation to obtain a prior authorization for my first visit here. I understand I will be responsible for full payment of any unauthorized visits. I also understand and accept responsibility for any balances unpaid by insurance due to deductibles, co-pays, uncovered services, etc. I hereby authorize direct payment from my insurance company to the Center for Life Solutions.

___Co-Pays: I am responsible for understanding my insurance benefits which includes co-pay amount and for paying my co-pay at the time of each session.

___Cancellation: I understand that if I cancel any appointment without 24 hours notice or fail to show up for my scheduled appointment, that I will be billed $100 for the session. I am informed that insurance does not cover this charge.

___Confidentiality: I understand that the communications between therapist and patient are confidential to the fullest extent of the law. I understand, however, that there are situations where information involved in this treatment may need to be shared with others (DCF, law enforcement, confidential supervision/consultation) in order to provide optimal care and/or attempt to insure safety for you or anyone else who may be at risk. I understand that therapists are mandated by law to report any suspicion, threat and/or act of violence, abuse, neglect regarding children, disabled and elderly. I understand that in certain court proceedings, Center for Life Solutions may be required by judicial mandate to release confidential information. Your therapist will always try to inform you and work with you as best as they can to ensure that you are part of this process, when possible.

___Professional Fees: I understand the hourly fees are as follows:

Counseling:	Intake 60 min.	$175	Executive Coaching: 60 min.	$175
	Individual 50 min.	$160	90 min.	$260
	Couples/Family	$170		
	Group	$55		

A prorated amount is charged for longer sessions and for other professional services related to my care. Other services not billable to insurance include report writing, telephone conversations lasting longer than ten minutes, consulting with other professionals, preparation of treatment summaries or any

additional services that I request. If I the client, become involved in legal proceedings that require the participation of my therapist, I agree to pay for all of her/his professional services and related time, even if she/he is called to testify by another party. Because of the complexity of legal involvement, the charge is $225 per hour for preparation and attendance at any legal proceeding or report writing used for legal purposes. This is because the therapist will need to obtain her/his own legal consultation. I will be informed verbally if this fee structure changes and may request an updated written copy of any changes.

___Voicemail and E-Mail: I understand my therapist will do everything to protect client confidentiality when using electronic forms of communication (voicemail, email, fax) but that complete confidentiality cannot be guaranteed. By choosing to provide my email address below, I agree to authorize my therapist to email me at this address. I understand that this is in a non-secure internet line. I will notify her/him if I do not wish to continue use of email. We will be sending out a monthly newsletter informing clients of upcoming events. If you wish at any time to be taken off this email list, please let us know.

Optional: My email address is:_____

___Emergency Procedures: In the event of an emergency, I will make every effort to reach my therapist by phone. If the emergency is such that it cannot wait for a return call, I will call 911 or go to the nearest emergency room. I understand that if my therapist is unavailable for an extended period, she/he will leave the name and phone number of a covering colleague on her/his voicemail message.

____Revocation: I understand that I may revoke this agreement in writing at any time. Exceptions to this revocation are: if action has been taken in reliance upon it; if there are obligations imposed on my therapist/Center for Life Solutions by my health insurer in order to process or substantiate claims; if I have not satisfied any financial obligations incurred.

____Communication with providers within Center of Life Solutions team. I understand that my provider will be communicating with other involved treatment providers on my behalf as needed. I have the right to cancel or modify this option at any time by informing my provider.

____Consent to Treatment: My signature below indicates that I have read this agreement, reviewed it with my therapist and that I agree to its terms. My signature also serves as an acknowledgement that I have received the HIPAA Notice of Privacy Standards.

Signature of client Printed Name Date

Signature of Therapist Printed Name Date