Informed Consent

Therapist:

Client:

I hereby authorize the psychological treatment and/or evaluation of myself, or my dependent, by the above-named therapist at Center for Authentic Living. I have discussed stated goals of psychological treatment and/or evaluation and I understand that I have the right to ask my therapist for information regarding diagnosis, goals for treatment, and estimated length of treatment.

I understand that if a therapist agrees to provide services to multiple people who have a relationship (such as spouses, significant others, parents and children), reasonable steps are taken to clarify at the outset (1) who the patient is and (2) the relationship the therapist will have with nonpatients.

I understand that personal notes taken by my therapist represent personal work product and are the property of Center for Authentic Living. I understand and agree that my therapist may properly retain such documents in my file according to professional standards.

I understand that the therapist is not required to release personal notes about my care, since these represent personal work product, and are not part of the formal record. Typewritten reports about my care can be sent out if provided with proper written authorization, and this will be done according to professional standards.

I have been informed of the procedure for reaching my therapist and I understand the policy regarding cancellations and missed appointments.

I understand that this agreement becomes part of my record, which is accessible to the parties at will, but to no other person without written consent.

I understand that the therapist will respect my right to maintain confidentiality of information communicated by me or obtained from me during the treatment period. I understand that there are legal limitations of such confidentiality (i.e., cases of suspected child or elder abuse, fear of danger to self or others, or if information is ordered released by Court Order).

Signature of Client or Legal Guardian: _____

Date: _____

Fee Agreement

Therapist:

Client:

I agree to pay in full for all services provided to me at Center for Authentic Living.

I understand and agree that I am responsible for any charges that are not covered by insurance or any other third-party payor. I also agree to assist my therapist in submitting claims for insurance reimbursement.

I agree that payment of insurance benefits be made directly to Center for Authentic Living. I authorize the release to insurance companies any information requested by them to determine their liability for claims submitted to them for reimbursement. This agreement covers the entire period of my relationship with my therapist.

I understand that copay, coinsurance, and deductibles must be paid at the time of service or when Center for Authentic Living receives an explanation of benefits in the mail.

I understand that I will receive an explanation of benefits in the mail for each service date.

I understand that providing a card to be put on file in the Center for Authentic Living credit card merchant system, means I will be automatically charged on a weekly basis for any balance due.

I understand that if I pay for any services or fees using cash or check, I must give it to my therapist in person, or mail it to Center for Authentic Living.

I understand that if I do not make payment for any services or fees, I will be invoiced within 2 months.

I understand that credit cards will be charged a 2.5% processing fee while debit cards and HSA cards will not be charged any fees.

I understand that there will be a $20.00 fee for a returned check.

I understand that there is a $90.00 cancellation fee for appointments cancelled in less than 48 hours or for no-shows.

Signature of Client or Legal Guardian: _____

Date: _____

Electronic Communication Policy & Agreement

Therapist:

Patient:

I understand that when I choose to communicate electronically with my therapist (including but not limited to email, text message, voice message, video chat, instant messaging) I am breaking confidentiality under the Health Insurance Portability and Accountability Act (HIPAA).

I understand that my therapist will do everything possible to keep communications confidential, including keeping passwords private, having locks (physical and/or electronic) on computers and cellular devices, and making use of encryption technology.

I understand that free email services, text messages, voice messages, video chats, and instant messaging are not encrypted.

Signature of Patient or Legal Guardian: _____

Date: _____