The Personal Wellness Center

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Telephone: 410-742-6016

Informed Consent for Treatment, Financial Policy and Agreement

Welcome to **The Personal Wellness Center**. This document contains important information about our professional services and business policies. It is important you read this document before signing it. When you sign it, it represents an agreement between us. If you have any question, please let us know.

CONSENT FOR TREATMENT

I voluntarily agree to receive evaluation/mental health treatment/therapy/counseling services by the counselors at The Personal Wellness Center. I understand and agree that I will participate in my treatment plan and that I may discontinue treatment and/or withdraw my consent for treatment at any time.

Therapy is a relationship between people that works in part, because of clearly defined rights and responsibilities held by each person. As a client in therapy, you have certain rights and responsibilities that are important to you and they are described in the following paragraphs.

Therapy has both, benefits and risks. Risk may include, experiencing uncomfortable feelings such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness, because the process of therapy often requires discussing the unpleasant aspects of your life. However, therapy has been shown to have benefits for individuals who undertake it. Therapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems. But, there are no guarantees about what will happen. Therapy requires a very active effort on your part. In order to be most successful, you will have to work on things we discuss outside of sessions. Appointments will ordinarily be 45-50 minutes in duration, once per week at a time we agree on, although some sessions may be more or less frequent as needed. You are responsible for coming to your session on time; if you are late, your appointment will still need to end on time.

CONFIDENTIALITY

We respect and honor your confidentiality. With your permission, we'll share only necessary information with your insurance company for billing purposes, doctors involved in your care, and only if necessary to a family member. There are a few instances when we are obligated by law and/or ethical standards to share information and they are: Harm to self or others, Abuse or Neglect, Court or other legal proceedings. If there is ever a need to reveal information, we will let you know in advance and work with you to handle the situation in a way that respects you, your feelings and your needs. More information about confidentiality is provided in the Notice of Privacy Practices form.

AUTHORIZATION TO BILL INSURANCE COMPANY

By signing this document I give my permission to The Personal Wellness Center to bill my insurance company for services rendered.

CONSENT FOR RELEASE OF INFORMATION

By signing this document I give my permission to The Personal Wellness Center to discuss my treatment goals, progress, and/or other aspects of the therapeutic treatment with my insurance company, my primary care physician, psychiatrist, and my emergency contact given in the Client Information form (if necessary).

Informed Consent for Treatment Continued

CANCELLATION POLICY

The time scheduled for your appointment is assigned to you and you alone. It is greatly appreciated that you give 24-hour notice when canceling an appointment. This gives enough time to make other arrangements and accommodate other clients' needs. It is understandable that illnesses, accidents and emergencies occur unexpectedly and there will be no choice but to cancel at the last minute. However, any other cancellations without 24-hour notice will be billed at the rate of $75.00 per session. We appreciate your consideration and understanding on this matter.

Note: Insurance companies do not cover missed appointments. This cancellation policy does not apply to Medicaid clients.

NON-SUFFICIENT FUNDS (NSF) CHECK POLICY

By signing this document I understand that checks returned for non-sufficient funds, stop payment requests, or a closed account will result in a $35.00 Returned Check Fee. I am responsible for paying The Personal Wellness Center the amount of the returned check plus the Returned Check Fee ($35.00) in cash.

FINANCIAL POLICY

By signing this document I understand that I am responsible for all charges incurred for services provided where there is no insurance coverage. All payments are due at the time of service.

_____

Printed client name

_____

Client's signature

_____

If under18, Parent/Legal Guardian Signature

_____

Relationship to client

_____

Date

_____ _____

Witness Signature Date