Linda S. Klein, LPC, PC, MA, RPT/S
4251 Date Street, Colorado Springs, CO 80917
(719)538-3264

CONSENT FOR TREATMENT

I consent to the evaluation and treatment process with _____________________(therapist name) and I understand that this process may include myself, my minor child, and/or other family members. I am aware that care and treatment is not an exact science and acknowledge that no guarantees have been made to me as the result of treatment. I understand that session length averages from 45-50 minutes and that if I am late for my appointment, my session length will be calculated from the beginning time of the appointment.

PAYMENT AGREEMENT

UNINSURED/INSURED PARTIES: I will begin counseling on _____________________. I understand that the fee for this service is $______________ for the initial session and $___________per client session hour. I agree to pay $_________ at the end of each session and agree that I will be responsible for all moneys not covered by my insurance plan or other monies as follows:

____

____

I understand that I will be responsible to pay, prior to my next appointment, the amount of my agreed full client hour upon missing an appointment without proper 24 hour cancellation.

I understand that counseling services are considered a medical expense and are frequently covered by health insurance, which requires a diagnostic determination. I also understand that my therapist does not assume a contractual agreement with my insurance company. In accepting counseling services, I agree to incur full financial responsibility for those services.

I understand that I will be charged for any requested court reports, mental health assessments, treatment summaries, letters, and/or any other documented information required of my therapist in the continuity of my care, not paid for by my insurance company. I will discuss these rates with my therapist.

I agree to the preceding relevant paragraphs.

____
Print Client Name

____ _____________________________
Signature of Client/Parent/Legal Representative Date

____ _____________________________
Witness Date