Parker Counseling Services Informed Consent Agreement

Name of Counselor ____________________

Dear Client:

Welcome to Parker Counseling Services. We are looking forward to working with you. The following policy statement will help clarify your responsibility regarding the development of your treatment plan, billing, and insurance.

Concerning insurance, it will be your responsibility to call your insurance company to verify your benefits. You agree that you are responsible for the charges for services provided by this therapist to you, although other insurance carriers may make payments on your account. You understand insurance deductibles, co-payments, or full-fee for services are due at the time of services.

You further guarantee that charges for services provided will be paid upon receipt of billing statements from this therapist/agency/our outside billing agency. The balance will be paid in full unless special arrangements are made for alternative payment scheduling. If such alternative arrangements are made, you guarantee that payment will be made in compliance with those arrangements. You understand that this office will bill insurance companies and other third-party payers, but cannot ensure such benefits. And is not responsible for the collection of such payments.

There will be a charge for all appointments that are missed or canceled without a twenty-four (24) hour notice. Insurance carriers will not pay for missed or canceled appointments.

Informed Consent: You have been provided with specific, complete, and accurate information about; The benefits and methods of treatment, Options to proposed treatments, Consequences of not receiving proper treatment, The tentative treatment plan, The client rights, confidentiality, and grievance procedure. This informed consent is effective until treatment is terminated.

Client Signature: ____________________________________ Date: ____________

Therapist Signature: ____________________________________ Date: ____________

Parker Counseling Services Payment Agreement

I, ______________________, request that the therapist/agency named above provide professional services to me and I agree to pay fee(s) of:

Normal Fees: $180.00 initial session and **$145.00** on all other sessions. Psychotherapy is provided in a 45 to 50 minute clinical hour instead of a 60-minute clock hour.

No-Show and Cancellation Fees: All appointments must be cancelled by 3pm the previous day, or by 3pm on Friday for a Monday appointment, to avoid charges for a *"no-show"* or *"late-cancellation."* After-hour messages regarding cancellations may be left on the Counseling Services phone line (303) 317-3088. You agree to be charged **$40.00** for a *no-show* or *late-cancellation* appointment. Insurance will not cover the costs of care for *"no-shows"* or *"late-cancellations."*

You also agree to pay **cash** or **check** to your counselor for co-pay and no-show fees. If you wish to charge by credit card, there is a handling fee.

Client Signature: ______________________ Date: __/__/_____

Therapist Signature: ______________________ Date: __/__/_____

Therapist/Agency Representative HIPPA Organization Number: 1073837431