

Consent to Treatment

By signing this form I am consenting to treatment by Life Transitions Counseling, LLC.

If an insurance company is being billed for your sessions, I am required to give a diagnosis to the insurance company in order for the sessions to be covered. You are welcome to ask at any time about the diagnosis being used in billing your insurance company.

By opting to bill your insurance provider for your sessions, you are consenting to information about you being shared with the insurance provider. This information includes the dates that you see me, the purpose of the visit, and a diagnosis.

Life Transitions Counseling, LLC. Policies

1. All sessions last 50 minutes. The fee per session is \$160.00 payable on the date of service.
2. **24-hour notice of cancellation is required. If notice is not given, you will be charged for the session.**
3. The content of all sessions is completely confidential unless permission is given to disclose any information regarding our work together. The only exception to this is if in my clinical judgment you pose a threat of harm to self or others, or if I should learn of any abuse to children or the elderly. By law, I am then required to get help for you, or the person who is in danger of being harmed or has been harmed. In any of these situations, I would discuss my plans with you before talking to anyone else. My only motive would be to keep you and others safe.
4. Phone contact between sessions is welcomed if you feel that it is important to speak with me before our scheduled session. It is important to know that I am not available 24 hours a day and calls may not be returned immediately. They will be returned within 24 hours during normal Monday-Friday business hours. If you are in crisis, and cannot wait to reach me, you should go to the closest emergency room or call 911.

I consent to treatment; and I have read, understand and agree to the above policies.

Signature _____ Date _____