CLIENT CONSENT FOR TREATMENT FORM
Please READ and SIGN

CONFIDENTIALITY

All sessions are completely confidential in accordance with law and recognized professional standards. If I, as your counselor, need to communicate to another about your case, you must give me written permission to do so. The only exception to this is, if in accordance with law and reasonable professional judgment, such communication appears needed to protect you or others from harm, or in response to legal process, or in other proper circumstances, the privileged nature of your communication ceased in these circumstances. Possible exceptions include, but are not limited to, the following situations: child abuse, abuse of the elderly or disabled, threats of suicide, and threats of homicide. Insurance companies are entitled to diagnosis, date, and type of service.

INFORMED CONSENT

Therapy is an interactive process between client and therapist, and the results of therapy depend on your cooperation. It is meant to promote change and understanding. Sometimes this process can be emotionally painful, and at other times, very fulfilling. You will be expected to contribute to all decisions regarding therapeutic interventions (including out of session assignments), treatment planning, and periodic treatment plan reviews. You have the right to refuse or alter any service and intervention. While I will use best effort to assist you, the nature of psychological services is there can be no assurances of results, and no promises can be made regarding the outcome of any services provided. You should question the rationale of any services, intervention, and discussion if these seem unclear to you. Additionally, I am being supervised by Shiloh Lundahl, LCSW. If you feel you are not receiving the services you desire or have concerns you can contact him at 602-492-5055.

FEE RATE

The basic fee has been discounted to **$80 per 50 minute session .** Longer sessions are prorated from those basic fees. Out-of-session phone calls providing therapeutic support or intervention will be billed at a fee of $35 for 15 minute increments.

PAYMENT METHOD

If a client chooses to pay by cash or check, payment is expected at the time services are rendered or before. If payment is not received at the time services are rendered, the debit or credit card on file will be charged for the services.

MISSED APPOINTMENTS

If you are unable to keep an appointment, please notify me immediately by phone, email, or text (480) 382-7866. If an appointment is canceled or missed **without 24 hours prior notice, you will be billed for the missed session at the rate of $50. Second and subsequent late cancellations will be billed the full fee.**

RESPONSIBILITY

The client (or responsible party) is considered responsible for payment of professional services. When you request to bill a third party, such as a church organization, and that third party fails to make payment within 30 days from the date of billing, payment is expected from client or responsible party within 10 days of receipt of statement.

CONSENT

I, voluntarily, agree to receive mental health assessment, care, treatment or services and authorize the undersigned therapist to provide such. I understand and agree I will participate in the planning of these services and I may stop such care at any time. By signing this consent form, I acknowledge I have both read and understood all the terms and information contained herein. Ample opportunity has been offered to me to ask questions and seek clarification on anything unclear to me.

_____	_____	_____	_____
Client Signature	**Date**	**Therapist , Linda Platt's Signature**	**Date**

CONSENT FOR TREATMENT OF MINORS UNDER THE AGE OF 18

I,_____ am the parent or legal guardian with legal custody of
(Parent/ Guardian Signature)

_____ and give permission to provide counseling services to my child(ren) identified above.