Systemic Perspectives, Inc.
Consent for Treatment

Welcome to Systemic Perspectives. Before therapy can begin, your signature(s) will be required on this informed consent document. Any questions you may have regarding this consent for treatment should be directed to your therapist.

Please read carefully, initial each paragraph and sign at the bottom.

_____I authorize Systemic Perspectives to release to my insurance company any information from my medical records which may be necessary to determine benefits and receive payments directly. **I understand that, although my health insurance may be billed, I am financially responsible for all charges incurred**.

_____Therapy sessions will be billed at _____ for an initial evaluation and _____ for therapy sessions. **Additional services (phone calls longer than 15 minutes, collateral meetings, writing letters or treatment summaries) will be billed at $100.00 per hour and are the client's responsibility.** A fee for missed appointments and sessions cancelled with less than 24 hours notice may be billed, which is not reimbursed by insurance. **Client payment is due at time of service**.

_____All client information and case records will be maintained in the strictest confidence under the law. No information will be released without client signed consent. If you would like to review your records, notify your therapist. The following exceptions apply in accordance with State and Federal laws: 1) court order compelling disclosure; 2) disclosure and action when there is reason to believe that a client is threatening to harm self or another person; 3) disclosure and action when there is reason to believe a child or vulnerable adult has been abused or neglected.
If you are being seen as a couple or family, your therapist will discuss confidentiality with you. In order to help you strengthen relationships within your family, it is important that the therapist not receive information that must be kept secret from other family members.

_____I have been provided a copy of the Notice of Privacy Practices for review. I understand copies are available, either in the office or on the clinic website: www.systemicperspectives.com.

_____Electronic communication is limited to administrative business. All other uses will be determined by the therapist, with additional consent. Recording of sessions is prohibited without permission from all parties. Therapists reached via emergency line may return calls using their cell phones, which are not a secure connection.

_____Our staff is dedicated to providing effective therapy. Some clients may experience increased distress when problems are first disclosed, but therapy outcomes are usually positive. Negative effects are rare. Treatment plans will be developed collaboratively to help you reach your goals. If you wish to file a grievance, you may speak to the privacy officer.

I consent to treatment which includes: _____ Individual Therapy _____Family Therapy _____Couple's Therapy.

This consent is valid for the entire course of treatment and may be withdrawn, in writing, at any time.

Client(s) signature

_____ Date_____

_____

Therapist signature _____ Date_____