Discovery Counseling Center Consent for Treatment (ADULT)

Patient's Name: _____

Therapist's Name: _____ # _____

☐ Fully Licensed Therapist ☐ Registered Associate Therapist* ☐ Intern/Trainee Therapist*

*Works under the supervision of Discovery Counseling Center's certified licensed Supervisors with whom cases are discussed.

CONFIDENTIALITY STATEMENT:

The therapist-client relationship and any information shared in therapy is confidential. I understand information will only be released with my written permission (which may be revoked in writing). According to California law, therapists are mandated reporters and must breach confidentiality under the following circumstances when there is a reasonable suspicion of:

A. An incident of **child abuse**, past or present
B. An incident of **elder abuse or dependent adult abuse**
C. Serious **threat of harm to oneself or to others** or to property
D. Certain other legal situations, such as a **court order** or a court-ordered evaluation

FINANCIAL AGREEMENT: **Session Fee: $150* Sliding Scale Rate: _____ Valid until: _____**

My payment method: ☐ Insurance ☐ Cash

*Payments from insurance will vary based on contracted rate. Sliding scale available based on ability to pay.

I understand the fee per 45-minute session (individual, couple, or family) is payable at the time of treatment. DCC will accept cash, a personal check, or credit card. I will be charged for a returned check (NSF) in the amount of $25. If I am paying with insurance there will be a $50 co-pay for sessions prior to confirmation of insurance coverage. If the resulting copay is more or less, I will be reimbursed or owe the remaining fee. If there is a deductible and it has not been met, I will owe the contracted fee until the deductible is met. I agree to provide information about changes to my insurance coverage as soon as possible. If coverage terminates for any reason, **I understand that I am responsible for all fees not covered by my insurance. I will be charged a full session fee for any appointments that I miss or that I cancel with less than 24-hour notice.** After 3 late cancellations or no-shows, I may lose my time slot and/or be referred to another provider. I will receive a receipt for monies paid to DCC. I also understand that fees may be changed periodically. In that event, I will be given a month's notice of any rate changes. All services are performed in the DCC offices unless otherwise stated. I understand that administrative staff may handle office and billing transactions as needed.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:

(Initials) _____ I acknowledge being offered the *HIPAA Notice of Privacy Practices*, which provides information about how my protected health information may be used or disclosed. The DCC *HIPAA Notice of Privacy Practices* is subject to change. If the notice is changed, you may obtain a copy of the revised notice by contacting 408-778-5120 or from the DCC web site.

I understand there is a possibility that stated goals may change during the therapeutic process and I understand that this agreement does not guarantee that I will attain my stated goals or possible future goals. My participation in therapy is voluntary and I may withdraw at any time.

In case of urgent situations between sessions, I have been told to call my therapist and specify that it is urgent and you will call us back as soon as possible. I have also been told that if it is an emergency to call 9-1-1 or the Emergency Psychiatric Services at 408-885-6100 or go to the nearest hospital emergency room.

I have read the above information and understand that I am liable for all costs of treatment. I give _____ permission to provide treatment for me.

Print _____ Sign _____ Date _____