Counseling Center of Montgomery County

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CONSENT TO SERVICES / RIGHTS ACKNOWLEDGEMENT

CONSENT TO SERVICES

I hereby request and consent to services for myself/dependent which includes therapy, diagnostic assessment, case coordination, consultation, and other treatment/services recommended and considered necessary by Counseling Center of Montgomery County, hereafter referred to as the clinic. I understand that developing a treatment plan with my therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process. I understand that no promises have been made to me as to the results of treatment or of any procedures provided by my therapist.

I am aware that I may stop my treatment with my therapist at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment (for example, if my treatment has been court ordered, I will have to answer to the court).

I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatment I receive at this clinic. I understand that if payments for the services I receive at this clinic are not rendered, then the clinic may stop my treatment.

I understand and have been informed that Licensed Professional Counselor – Interns may be involved with my treatment and sessions.

I have been informed that any information regarding services at Counseling Center of Montgomery County are subject to release only by my informed and written consent or by subpoena and/or court order. I have also been informed that patient identifying information about me may be exchanged between office staff and other designated/contracted providers for continuity of care purposes.

I authorize this clinic to release any medical information necessary to process claims for the services provided. I authorize payment of governmental/medical benefits to this clinic for services provided. I understand that I remain responsible for any and all charges not met by my insurance company.

____________ Initials

CONSENT FOR TREATMENT OF MINOR

I authorize this clinic to provide services for ____. I agree to follow-up with phone conversations regarding progress in therapy and to participate in therapy as recommended.

Client Signature　　　　　　　　　　　　　　　　　　　　Date

Parent or Representative Signature　　　　　　(relationship)　　　　　　Date