Comprehensive Counseling Center

CLIENT INFORMATION AND INFORMED CONSENT

I have chosen to receive treatment services from Comprehensive Counseling Center. My choice has been voluntary and I understand that I may terminate therapy at any time.

I understand that state and local laws require that my therapist report all cases of abuse or neglect of minors or the elderly.

I understand that state and local laws require that my therapist report all cases in which there exists a danger to self or others.

I understand that there may be other circumstances in which the law requires my therapist to disclose confidential information.

I understand that it is my responsibility to pay all session fees, co-payment, or co-insurance at the time of service and this demonstrates my commitment to improve my health. All professional services rendered are charged to me. Necessary forms will be completed to expedite insurance carrier payments. My records may be released to the insurance company and to the primary care physician for case management and coordination of treatment.

I understand that a voice-mail number is available to reach my therapist, 24 hours a day. In cases of emergency and when a quick response is necessary, I understand that I should call my local crisis center or emergency room.

I understand that I will be charged a $50.00 fee for a check returned unpaid by my bank. I will also be charged for any expenses incurred in the collection of any unpaid fees.

I understand that sessions are scheduled in advance, last 45-50 minutes, and require regular attendance to ensure optimum therapeutic benefit.

I understand that 24 hours notice is required if I am not able to attend a scheduled session. Without such notice, I agree to pay a $75.00 missed session fee.

I certify that I have read, understood and agree to the terms described above.

_____ Date_____

Client Signature

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Printed Name