Palmetto Counseling & Consulting Services, LLC

Consent for Treatment: Pre-Paid Counseling Packages
(Available to Self-Pay Clients Only)

Palmetto Counseling recognizes the needs of clients who may be uninsured, have high deductibles, or do not have mental health, family or marriage counseling benefits as part of their insurance plan. For self-pay clients without insurance, Palmetto Counseling is pleased to offer discounted rates for pre-paid packages for Individual, Family, and Marriage / Couples Counseling office visits.

Please Note: To be eligible for discounted rate, pre-payment is required and client understands and agrees that insurance claim will not be filed. As such, Palmetto Counseling will only provide a receipt for proof-of-purchase of pre-paid counseling package and will be unable to provide clinical receipt, diagnosis information, CPT procedure codes, or any other clinical information for client to file claim with their insurance.

I agree to take part in psychotherapy/counseling at Palmetto Counseling & Consulting Services, LLC. I understand that developing a treatment plan and regularly reviewing our work and goals is in my best interest. I agree to play an active role in the process.

I understand that psychotherapy/counseling has potential risks and benefits. I understand that no promises or guarantees have been made to me as to the results or success of treatment.

I also understand that I may withdrawal from treatment at any time. Withdrawal of consent can be in any form: verbal, active resistance, repeated noncompliance, or any other unwillingness to continue participating in treatment. If I withdraw consent I will be responsible for paying for the services that I have already received.

I acknowledge that if I must cancel an appointment, I must cancel within 24 hours of the appointment. If I do not cancel or fail to show, I may be charged for the full charge of the missed appointment. I ALSO UNDERSTAND THAT I AM RESPONSIBLE FOR FINDING A NEW THERAPIST IF I FAIL TO SHOW FOR TWO CONSECUTIVE APPOINTMENTS WITHOUT PROVIDING 24-HOUR NOTICE. PALMETTO COUNSELING WILL NOT CONTINUE TO PROVIDE SERVICE AFTER TWO NO-SHOWS.

My signature below shows that I understand and agree with all of the above statements. The risks, benefits, side effects, and alternatives of treatment as well as the consequences of non-compliance with treatment have been discussed with me and I have had the opportunity to ask questions. **If the client is a minor or has a legal guardian appointed by the court, the client's parent(s) or legal guardian(s) appointed by the court, the client's parent(s) or legal guardian(s) <u>must sign this consent and provide copies of Court/Custody Papers (if applicable).</u>**

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Printed Name Date

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Client / Parent / Guardian Signature Date

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Staff Witness Date

Coordination with Primary Care Physician or Psychiatrist (if applicable)

It may be beneficial for our practice confer with your Primary Care Physician or Psychiatrist (if applicable) with regard to your mental health treatment. In addition, some Managed Care Plans require that we notify your physician/ psychiatrist by telephone or in writing concerning mental health services, unless you request that notification not be made. This information will not be released without your consent, except in an emergency.

Please check one of the following:

____**I do** authorize Palmetto Counseling & Consulting Services, LLC to contact my Primary Care Physician or Psychiatrist whose name and address are shown below to discuss the diagnosis, treatment plan, and prognosis while under Palmetto Counseling & Consulting Services, LLC care. In addition, Palmetto Counseling & Consulting Services, LLC is authorized to obtain information from my Primary Care Physician or Psychiatrist concerning my medical diagnosis and treatment.

____**I do not** authorize Palmetto Counseling & Consulting Services, LLC to contact my Primary Care Physician or Psychiatrist whose name and address are shown below to discuss the diagnosis, treatment plan, and prognosis while under Palmetto Counseling & Consulting Services, LLC care. I am providing Palmetto Counseling & Consulting Services, LLC with the name and address of my Primary Care Physician or Psychiatrist for informational purposes only. **Primary Care Physician / Psychiatrist**____

Telephone(   )_________________**City**______________**State**______**Zip Code**_____________

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Client / Parent / Guardian Signature Date

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Staff Witness Date