Consumer Consent For Treatment

Please read carefully and initial indicating that you have reviewed the following information . Your initials indicate your agreement.

_____I hereby request admission to KCC, counseling with Samaria M Colbert MSW LCSW evaluation and or treatment. If evaluation indicated that admission is appropriate. I consent to such services as indicated by my clinician responsible for my care. If the evaluation indicated that I would not benefit from services at the agency I will be referred to a more appropriate resource with my person. I also understand that my consent can be withdraw at any time.

_____I understand that my therapist, does not make clinical judgement calls in regards to my ability to work, does not assess for work capability, DOES NOT complete documentation to disability determination stating such. The therapist DOES NOT complete FMLA paperwork or sign for clients to be out of work for any period of time other the time in time out of the therapy appointment. I may request copies of my records indicating mental health diagnosis, treatment, notes as I consent at any time. There is a 15.00 charge for a request for records. This is not paid by your insurance company.

_____I hereby grant Samaria M Colbert, KCC to release of information to my insurance company in order to process and pay claims for services rendered to me. I understand that this consent allows the release of all information in my client record including substance abuse, communicable diseases including but not limited to (HIV, AIDS) and other sensitive services as specified in the need.

_____I hereby authorize payment directly to Samaria M Colbert, KCC of any insurance government program benefits otherwise payable to me for services rendered. I am financially responsible for any charges not paid under this assignment. I am responsible for ALL charges not paid for by my insurance company. Any refunds due me shall be applied to any other outstanding balance for which Samaria M Colbert, KCC is responsible. I will notify Samaria M Colbert, KCC of any charges in my financial status.

_____I consent to be contacted by KCC, Samaria M Colbert to assess my satisfaction with the service.

_____I understand if I participate in group treatment, I will keep all information discussed in group confidential.

_____I understand that my therapist does not make court appearances on my behave, does not make statements in regards to legal proceedings. Does not make judgements in regards to any custody issues, placement or reunification. If my therapist is summoned to court on my behave for any reason, I will be charged a fee of 150 dollars per hour, which is to be paid in full before my next therapy appointment and is not covered by my insurance.

_____I understand that all information is confidential, and private in compliance with laws that govern health treatment and protected health information. However, I do understand that exceptions to this statue include but are not limited to any threat of plan of harm to myself or another. If my therapist is concerned about my safety or the safety of others, she is obligated to breach this agreement and follow through with the most appropriate actions as need. This action could include, involuntary commitment, authorities such as police called. I understand that if I am involved in any court proceeding my records can be subpoenaed for court purposes. By law my therapist is then obligated to release any or indicated records.

_____I understand if I am unable to attend my appointment, I must cancel my appointment within 24 hours of my scheduled appointment. There is a 50.00 cancelation fee for all appointments if I do not call within 24 hours of my canceled appointment. If I am more than 15 minutes late it is considered a no call no show and I will be responsible for the 50.00 fee. If I do not show for my scheduled appointment for any reason, I will be charged this fee. All outstanding fees must be paid before my next appointment. I understand that my credit card will be charged for this fee.

_____I understand that my co-pay, co-insurance, deductible must be paid upfront at the time of the session. My therapist does not issue promise to pay later, after session invoices or reduce my payment as this is assigned by the insurance company. I understand that my insurance requires my therapist to obtain the payment at the time of service. My therapist does not discount my service, co-insurance, deductible or copay because he or she is contracted with my insurance company and must maintain these requirements as specified by the contract between the therapist, and the insurance company.

While we try to be as accurate as possible when verifying benefits, your fees may change depending on your eligibility and benefits during the date of your sessions. This is an estimate as of today, and we won't know your exact fee until we bill your insurance and get your explanation of benefits back from your insurance company. You are also encouraged to call the number on the back of your insurance card and ask your member representative what your 'mental health, outpatient, office visit' benefits are. Please let me know if you have any questions.

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Signature of client/legally responsible Signature of my therapist/KCC representative

Date_____ Date_____