OLNEY
Counseling Center, LLC
Providing help and hope for those in need.

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Consent for Treatment * Confidentiality * Financial Policy 2019

Consent for Treatment:

I, _____, authorize and request that Masha Levy LMSW, a Licensed Graduate Social Worker under the direct supervision of Kim Wells, LCSW-C [a Licensed Certified Social Worker/Clinical Licensed Counselor], carry out psychological examinations, treatments and/or diagnostic procedures which now or during the course of my care as a patient are advisable. I understand that the purpose of these procedures will be explained to me and be subject to my agreement. I understand the purpose of the service to be one or a combination of individual therapy, group therapy, and family therapy. I hereby give my written consent to have the above mentioned LMSW, an unlicensed therapist, disclose any medical, psychological or personal information concerning me to Kim Wells, LCSW-C.

I acknowledge that my therapist is not available 24 hours a day via any communications method (phone, texts, email, and website). **I understand for emergencies, I should contact both clinician and/or contact emergency services by calling 911.**

I have read this Consent for Treatment and I understand it fully, and voluntarily sign:

_____
Client, Parent, or Managing Conservator Date

Limits of Confidentiality:

I further understand that my privilege of confidential communication will be maintained by the therapist with the *following exceptions*:

 Should there be an allegation of child or elder abuse or neglect, the treating clinician has an obligation to report any pertinent information to the proper authorities and may be asked to testify in court regarding that information, and will, if subpoenaed to do so.
 Should there be any expressed intention to harm another or oneself, the treating clinician has an obligation to report this information to the appropriate authorities and to make a reasonable effort to prevent such action and will do so.

I have read this Confidentiality Agreement and I understand it fully, and voluntarily sign:

_____
Client, Parent, or Managing Conservator Date

Financial Agreement:

I understand that I am fully responsible for payment at time of service of entire fee or insurance copay/coinsurance for services. I acknowledge it is my responsibility to determine whether treatment services are covered by my insurance company and if needed, to obtain pre-authorization of services. If pre-authorization is not obtained, or there is a deductible which has not yet been satisfied, I understand I am responsible for the entire bill.

I understand that there is a $100.00 charge for no shows, and $100.00 charge for cancelling without 24 hours' notice, not reimbursable by insurance. I understand that phone and web sessions may not be covered by insurance and I am fully responsible for payment.

I have read this Financial Agreement and I understand it fully, and voluntarily sign:

_____
Client, Parent, or Managing Conservator Date