SHERMAN COUNSELING
Improving Quality of Life

CONSENT TO TREATMENT

We realize that you have many options in choosing your healthcare providers and we appreciate you choosing Sherman Counseling, LLC.

I and/or members of my family will be receiving therapy, assessment and / or psychiatric services at Sherman Counseling, LLC beginning on this date. All policies, procedures and possible alternative methods of treatment have been explained to me by my therapist or provider. I have been informed of my client rights and authorize Sherman Counseling to provide mental health and / or services identified as appropriate. I have been informed of the benefits of proposed treatment, the way treatment is to be administered, approximate length of treatment and any side effects which are a reasonable possibility, including risk of side effects from medication. I have also received information regarding alternative treatment methods and probable consequences of failure to receive treatment, as well as after hours crisis coverage. This consent remains in effect throughout the duration of treatment (12 months maximum), and may be withdrawn by written request at any time. I am aware that my case will be periodically reviewed by Sherman Counseling, consulting psychologists, psychiatrists and affiliated staff members.

Cancellation Policy: Failure to give 24 hour notice of cancellation will result in a missed appointment / late cancellation fee of a minimum of $150 except in the case of emergency. This will be charged to you directly and will not be covered by insurance.

SOCIAL MEDIA & ELECTRONIC COMMUNICATION

I understand that...

- At times, your provider(s) may seek information on the Internet about you for risk management or other clinical purposes. If this happens, you will be told about any Internet searches and have an opportunity to correct any incorrect information.
- Sherman Counseling staff do not accept social media requests from clients on their personal accounts. If you follow Sherman Counseling, please do not discuss individual treatment.
- I am not to text, record or take messages during our sessions.
- Sherman Counseling staff can use email to communicate with you about administrative details, such as appointment times, and cancellations, but we cannot do therapy. E-mail is not secure or confidential.

FINANCIAL OBLIGATIONS

There are two possible methods of payment for services that have been explained to me. My selection is initialed below:

_____ (Initials) I have insurance and authorize Sherman Counseling to submit billing to my insurance company or third party carrier. I give permission for Sherman Counseling to submit any additional information necessary to process my insurance claim if requested by my insurance carrier.

Please be aware that most insurance benefits include a deductible and co-payment. Please contact your insurance carrier for this information. Deductible and co-payment are due at the time of service.

I am responsible for the payment of any deductible or co-payment and all charges not covered by insurance. It is my responsibility to provide Sherman Counseling with all necessary insurance information and to notify the office if there is a change in my insurance status. I understand that Sherman Counseling will send a monthly statement to my home and I agree to make a personal payment on the outstanding balance. Any payments in excess of my insurance payments will be refunded to me by Sherman Counseling.

OR

_____ (Initials) I do not have insurance or do not wish to utilize my insurance coverage and agree to pay the self-pay rate of $_____ for the initial appointment and $_____ for follow up sessions due at the time of each session.

Please check that you have been offered the following documents…

( ) I acknowledge that I was offered a copy of Client Rights and the Grievance Procedure for Community Services.
( ) I acknowledge that I was offered a copy of Sherman Counseling's policy for involuntary termination of services.
( ) I acknowledge that I was offered the Notice of Privacy Practices (including Protected Health Information & Confidentiality)
( ) I acknowledge that I was offered a copy of my patient expectation form for psychiatry services

_____ Print Name _____ Client signature _____/____/_____ Date

_____ Parent - Print Name _____ Parent Signature _____/____/_____ Date

_____ Witness _____/____/_____ Date

Revised 1/2019