NETT-WORK FAMILY COUNSELING, LLC
CONSENT TO TREATMENT

Thank you for choosing, ______________________________, an Independent Practitioner at Nett-Work Family Counseling as your health care provider. I am committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of your Consent to Treatment and our Financial Policy, which you are required to read and sign prior to any treatment.

Regarding Insurance:

Please keep in mind that all charges are the responsibility of the patient regardless of your insurance coverage. We will be happy to file your claims with your insurance carrier(s). However, if your insurance hasn't paid within 60 days, we will expect you to work with your insurance company to receive reimbursement. If no payment has been received within 90 days of the date of service, you will be billed for the full service rendered. Co-payments & deductibles are due at the time of service.

Confidentiality:

Information regarding your treatment at Nett-Work Family Counseling is confidential and will not be released without your written consent. Information regarding your minor child will not be released without your written consent. Certain exceptions to these rules exist – should you be a danger to self or others, then the proper authorities must be contacted; or to the courts if records should be requested by them.

Minors:

All information pertaining to minors will be released to their parents or legal guardians upon their request, unless it would seriously affect the therapeutic process. The parents or guardian of the minor are responsible for full payment. **In divorce situations, the parent that brings the child to the appointment is responsible for payment regardless of the divorce decree.**

Treatment:

It is the policy of the clinic that each client will receive specific, complete and accurate information regarding the treatment that they receive at this clinic. This information will be in both written and verbal form. All clients are required to sign their treatment plan.

- Treatment shall be done in the following modes-individual, couple, family, or group.
- If you would like to receive a different treatment mode, transfer to another therapist, or to seek treatment elsewhere, then you are free to do so.
- You are free to withdraw this consent, which is good for 15 months, at anytime and to terminate your treatment.

Treatment Alternatives:

There are multiple alternatives to outpatient behavioral health/AODA treatment, including [but not limited to]: bibliotherapy (reading books), religious care, community support, AA/NA, holistic healing, alternative medicines such as acupuncture or energy healing, nutritional healing, and aromatherapy.

Possible Outcomes, Benefits, and Side Effects:

The overall benefits of treatment at Nett-Work Family Counseling include [but not limited to] improvement in mental health, physical health, family functioning, improvement in all relationships, social functioning, employment functioning, resolution of legal distress, and/or reduction of substance use concerns. As clients participate in outpatient treatment, many difficult and stressful issues might be addressed. Therefore, at times, side effects of treatment might include a temporary increase in negative symptoms. We encourage you to discuss this with your primary treatment provider as these issues arise. Also, by not receiving any treatment, it is probable that there will be no change, or an increase, in symptoms.

Emergencies:

The clinic has voice mail with an after hour's emergency cell phone number of the Director, Christine Nett, LCSW.

Cancellations and Changes of your Appointment Time:

Unless cancelled, at least 24 hours in advance, our policy is to charge <u>$55.00</u> for a late cancel or missed appointment. Please help us to serve you better by keeping scheduled appointments.

Client's Responsibility:

All clients are responsible to provide the clinic with accurate insurance information and to contact us should coverage be changed. The office manager will verify policy benefits and limitations, but the clinic will not be responsible for any changes in your insurance benefits.

Statement of Agreement:

Thank you for understanding our Consent to Treatment. Please let us know if you have any questions or concerns.

I understand and agree to this Consent to Treatment policy.

- ***Copy Given to Client***

______________________________________ ____________________

Client / Responsible Party Signature **Date**

<u>Please fill out the other side too</u> →