



TREASURE WELLNESS COUNSELING AND TRAINING CENTER

ADMINISTRATIVE OFFICE

3006 E. GOLDSTONE DR., MERIDIAN, ID 83642

208-515-7661

WWW.TREASUREWELLNESS.COM

AGREEMENT TO PAY FOR PROFESSIONAL SERVICES

I request that _____ provide professional service to,
(Counselor Name)

myself _____ and/or _____,
who is my _____.

- I agree to pay the counselors stated fees as listed in Informed Consent document and posted in the Treasure Wellness Counseling and Training Center Lobby.
- I agree that this financial relationship with this counselor will continue as long as the counselor provides services or until I inform him/her, in person or by certified mail that I wish to end this professional relationship.
- I agree to meet with my counselor at least once before stopping therapy.
- I agree to pay for service provided to me or stated client up until the time that I have fulfilled my financial responsibility.
- I agree that I am responsible for the charges of service provided by this counselor, although other persons or insurance companies may make payment on my or clients behalf.

Client/Guardian Signature

Relationship

Date

Client/Guardian Signature

Relationship

Date

I, the counselor, have discussed the issues above with the client and/or the person representing the client. My observations of the person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

Counselor

Counselor Signature

Date

PAYMENT INFORMATION

Acceptable forms of payment: Cash, Check, Credit, and Debit

Please make checks payable to: Above listed counselor or as directed

For ongoing credit and debit payments:

Name as it appears on Card: _____ Amount of Payment: _____

Billing Zip Code: _____ Frequency of Payment: _____

Card#: _____ Expiration Date: _____ Security Code: _____



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CONSENT FOR TREATMENT AND ACKNOWLEDGMENT

I, hereby acknowledge that I have received, read and been given an opportunity to ask questions regarding the following Treasure Wellness Counseling and Training Center business documents. I understand that if I have any questions or concerns regarding these business documents, I may contact my clinician or the TWCTC office.

- Your Counselor's Informed Consent and Procedures
- Treasure Wellness Counseling and Training Center Informed Consent and Procedures
- Client Bill of Rights
- Agreement to Pay
- Cancellation/No Show Policy – May Be Subject to ½ Billable Rate
- Insurance Assignment of Benefits
- Emergency Procedures
- HIPAA-Notice of Privacy
- Authorization for Live Observation
- Authorization for Audio-Video Recording

I, voluntarily consent to the live observation of session by TWCTC Interns, Affiliates, Supervisors or Intern University Representative.

YES NO

I, voluntarily consent to audio-video recording of sessions by TWCTC Interns, Affiliates, or Supervisors for educational training use.

YES NO

I, voluntarily consent to participate in the intake, assessment and treatment process. I also acknowledge the following:

1. I have been given the opportunity for discussion of any concerns that I have regarding treatment.
2. I will be informed and take part in my treatment and goal planning.
3. I have been given no guarantee of treatment outcomes.
4. I have been informed of any and all fees associated with my treatment.
5. TWCTC will use and disclose personal health information for treatment and to receive payment for services provided.

Printed Name of Client

Signature of Client

Date

Printed Name of Parent/Guardian

Signature of Parent/Guardian

Date

Printed Name of Parent/Guardian

Signature of Parent/Guardian

Date

Printed Name of Counselor

Signature of Counselor

Date