**CORNERSTONE COUNSELING, BRANDON DIXON LLC**

**2909 Bent Avenue, Unit B1**

**Cheyenne, WY 82001**

**INFORMED CONSENT FOR TREATMENT and FEE SCHEDULE, page 1**

I acknowledge I have received information about the therapy I am considering. I have been provided with the following documents from Brandon Dixon: **Notice of Privacy Practices**, and the **Welcome Letter**. Additionally, I have had my questions answered fully.

I hereby seek and consent to take part in treatment by Brandon Dixon, LCSW. I understand developing a treatment plan with my therapist and regularly reviewing our work toward meeting treatment goals are in my best interests. I agree to play an active role toward meeting treatment goals as agreed upon.

I understand no promises have been made to me regarding treatment results or outcomes, or of any procedures provided by the therapist.

I am aware I may terminate treatment services at any time. I will still be responsible for paying for services already received. I understand I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court).

I know I must call to cancel an appointment at least 24 hours before the appointment. Cancelations or not showing up may be addressed as a therapeutic concern. If I need to cancel within 24 hours of my appointment due to illness or extenuating circumstance, I will let Brandon know as soon as possible. If I “late cancel” or “no show,” Brandon has the right to charge me a fee of $50 the first time, then $100 after.

I am aware an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), diagnoses, and providers of any services or treatment I receive. I understand if payment for services I receive is not made, the therapist may stop my treatment. I also understand any information needed to collect unpaid fees will be released to collection agencies, attorneys, or others necessary for the collection of fees for services that have been rendered.

I understand and agree payment for all services is my responsibility. The undersigned requests payment of authorized benefits for services furnished by Brandon Dixon, LCSW is made directly to Cornerstone Counseling, Brandon Dixon. In the event the undersigned is paid directly by an insurance company instead, the undersigned agrees to promptly pay Cornerstone Counseling, Brandon Dixon. Payments and co-pays are due at time of service. It is your responsibility to know your insurance coverage and receive appropriate pre-authorizations. Cornerstone Counseling, Brandon Dixon provides insurance billing as a courtesy to you.

**Fee Schedule** **(Most Common Services)**

Initial Intake billed to insurance (CPT 90791): $230

Full Session billed to insurance, approximately 55 minutes (CPT 90837): $205

Abbreviated Session billed to insurance, 38 to 52 minutes (CPT 90834): $160

Brief Session billed to insurance, 16-37 minutes (CPT 90832): $115

Complexity Code Add-On: $25

For those not using insurance please discuss fees with Brandon Dixon, LCSW.

\_\_\_\_\_\_ Initial here if you **DO NOT** wish insurance to be billed for services rendered by Cornerstone Counseling, Brandon Dixon LLC and you are agreeing to pay fees in cash or credit.

\_\_\_\_\_\_Initial here if you **DO** wish insurance or another third party to be billed for services rendered by Cornerstone Counseling, Brandon Dixon LLC, with the understanding you are still responsible for fees incurred.

My signature indicates I understand and agree with all the statements in the Informed Consent for Treatment.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Client Name Date of Birth

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Client (or person acting for client) Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name of person acting for client Relationship to client (parent, self, etc…)

I, the therapist, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person’s behavior and responses give me no reason to believe this person is not fully competent to give informed and willing consent to receive treatment services from me.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Brandon Dixon, LCSW- WY#1008 (Therapist) Date

Copy accepted by client Client requested copy kept by therapist

This is a strictly confidential patient medical record. Law expressly prohibits re-disclosure or transfer.

**INFORMED CONSENT FOR TREATMENT and FEE SCHEDULE, page 2**