Consent to Treatment

(Adult): I consent to the use of a diagnosis in billing and to the release of that information to obtain payment of claims. I agree to pay the stated fees. I know I can end therapy at any time and that I can refuse any requests or suggestions made by Lisa Alber, LICSW. I am at least 18 years old.

Signed: _____ Date: _____ Signed: _____ Date: _____

Both legal parents must consent to treatment or provide proof of custody.

(Minor): As parent/legal guardian, I give consent to Lisa Alber, LICSW, to provide therapy necessary or advisable for my child _____, Date of Birth _____.

I understand that I and/or my child can stop treatment at any time. I will be notified, as will appropriate authorities, if issues are raised, which in the therapist's judgment endanger my child's welfare. (See: Limits on Confidentiality)

In counseling adolescents, confidentiality is suggested for the therapeutic process to work. While you as parent or guardian may have a legal right to information, your child may lose confidence in the process and the benefits of the therapy may be lost if you insist on knowing details of sessions.

Signed: _____ Date: _____ Signed: _____ Date: _____

Your initials below indicate that you have read and understand the four (4) documents listed below, you have had sufficient time to ask any questions, and agree to the terms specified in the documents. These forms are also located at LisaAlberTherapy.com.

____ ____ **Release to insurance**. I authorize Lisa Alber, LICSW, to release the necessary information to my
initial initial insurance company for authorization and billing purposes and/or to discuss claims.

____ ____ I have read and understand the **Welcome!** document.
initial initial

____ ____ I have read and understand the **Limits on Confidentiality**.
initial initial

____ ____ I have read and understand the **Notice of Privacy Practices**.
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____ ____ I have read and understand the **Client Rights and Responsibilities Statement**.
initial initial

_____ _____ **Electronic Communications**. I understand that email and text communications may not be
initial initial secure and by engaging in these forms of communication I accept the responsibilities and risks.

____ ____ **I am responsible for all co-pay, co-insurance and deductible fees and other fees** (payable at each
initial initial session). I agree to be charged $50.00 if I fail to provide 24 hours cancellation notice or "No Show" for my appointment. I agree to the $110/hour which is charged for my time spent outside of sessions preparing records, writing reports and letters, school meetings, etc., or to attend court, depositions or other legal proceedings. I agree to the $35 returned check fee.