Consent to Treatment

ADULT/COUPLE: 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.

X Print Name: _____ Signed: _____ Date: _____

X **Print Name: _____ 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, I prefer to keep confidentiality as much as possible in order for the therapeutic process to work. While you as parent or guardian may have a legal right to information, know that if you insist on knowing what is being said, your son or daughter may well lose confidence in the process and the benefits of the therapy may be lost.

X Print Name: _____ Signed: _____ Date: _____

X Print Name: _____ Signed: _____ Date: _____

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The following forms are listed on my website at **LisaAlberTherapy.com**. Your initials below indicate that you have read and understand the first four (4) documents listed below, have had sufficient time to ask any questions, and agree to the terms specified in the documents. You may request a copy at any time.

Initial Initial

_____ _____ I have read and understand the **Welcome! document**.

_____ _____ I have read and understand the **Limits on Confidentiality**.

_____ _____ I have read and understand the **Notice of Privacy Practices.**

_____ _____ I have read and understand the **Client Rights and Responsibilities Statement**. I authorize Lisa Alber, LICSW, to release the necessary information to my insurance company for authorization and billing purposes and/or to discuss claims.

_____ _____ **Electronic Payments and Communications**. I understand that email, text, electronic payments and electronic communications of any kind may not be secure. By engaging in these forms of communication I accept full responsibilities and risks.

_____ _____ **I am responsible for all co-pay, co-insurance and deductible fees, payable at each session. Sessions not cancelled within 24 hours are charged $120.** I agree to a $35 returned check fee. I agree to pay $120/hour which is charged for time spent outside of sessions preparing records, writing reports/letters, school meetings, or attend court/legal proceedings.

(Updated Jan 2023)