The Center
for Neuropsychology
& Counseling P.C.

Consent to Treatment

I acknowledge that I have received and understand the "Information for Clients" brochure and/or other information about the therapy I am considering. I understand that if I have any questions, I can ask my provider or the owners of The Center.

I consent to take part in treatment with The Center for Neuropsychology and Counseling, PC and/or its associates. I understand that developing a treatment plan with my therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process and to work to the best of my ability to achieve these goals.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided.

I am aware that I may stop my treatment at any time. I will still be responsible for is paying for the services I have already received. I understand that 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 agree to call to cancel an appointment at least 24 hours before the time of the appointment. If I do not cancel or do not show up, I will be charged for that appointment.

The Center is an out-of-network provider. I will be responsible for the entire cost of my care on the day services are rendered. The Center can provide an itemized claim form for my submission to my insurance company.

For our MEDICARE patients: I request that payment of authorized Medicare and/or Insurance benefits be paid directly to The Center for Neuropsychology and Counseling, PC. I permit a copy of this authorization to be used in place of the original. I authorize the release to the Social Security Admin, Centers for Medicare and Medicaid Services or its intermediaries, or to my medical insurance carriers any information regarding this or related claims. I understand that I am responsible for any co-pays, deductibles, co-insurance amounts and non-covered services.

My signature below shows that I understand and agree with all of these statements.

_____ _____

Signature of client (or person acting for client) Date

_____ _____

Printed name/Date of birth Relationship to client

I, the provider, 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 that this person is not fully competent to give informed and willing consent.

_____ _____

Signature of therapist Date

☐ ❑ Copy accepted by client ☐ ❑ Copy kept by therapist

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.