Consent to Treatment and Agreement

WCT Health & Wellness would like to extend our appreciation for the opportunity to work with you and your family. We look forward to an ongoing professional relationship with you now and in the future. In order to facilitate our mutual cooperation and understanding, we would like to advise you as to your right to consent to treatment and highlight my administrative and financial policies for your review and agreement. We provide medication management, primary care services, therapeutic assessment, counseling, and psychotherapy services for individuals, children, couples, families, and corporate clients using a variety of methods and client-specific treatment options. At the outset of our working relationship, you have the right to consent, or to refuse to consent, to receive diagnostic evaluation, examination, counseling, and treatment; your consent is deemed to be given and effective by your signature at the end of this form, and such consent shall remain effective until and unless revoked in writing later. Note that express authorization through your signature of an additional, distinct form (titled "Authorization to Release Information") is required in order for myself or my office to disclose or exchange records pertaining to your mental and/or medical health, psychiatric and/or psychological evaluation and/or treatment, HIV/AIDS diagnosis and/or treatment, and drug and/or alcohol abuse.

Please be advised of the following policies of the practice of WCT Health & Wellness

☐ I expect that you will render payment for services at the time that such services are provided unless you have made special arrangements with our office in advance.

☐ If you elect to make Out-of-Pocket payments, you agree to pay at the rate of $250.00 intake and $125.00 per session. Out-of-Pocket fees are due at the time of visit and will not be billed to insurance.

☐ You are responsible for providing our office with advance notice of any changes to your insurance.

☐ Claims for any sessions denied by an insurance company due to your negligence will be billed/charged in full to you.

☐ **You are responsible for setting and keeping scheduled appointments. Missed sessions or sessions cancelled less than 24 hours prior to the appointment will be billed at $85.00 per session and are not billable to insurance.**

☐ If **you do not contact the office in regard to missing an appointment within 24 hours or if are no show your file will be closed and you will be responsible for securing another medical provider. No medication refills will be provided.**

☐ All out-of-session services provided are not billable to insurance and will be billed at $100.00 per hour based on the amount of time devoted to these services. These services may include responding to emails, speaking with other providers, and phone calls/text messages with you and/or your family members outside of a 10-minute time frame. Any written report will be billed at $150.00 per hour.

☐ My presence at court is billed at $300.00 per hour (including travel time).

☐ My presence at a school-based meeting is billed at $300.00 per hour (including travel time). You hereby agree to allow WCT Health & Wellness to bill you for any of the above services if not paid in full at the time of visit.

You hereby authorize WCT Health & Wellness to file any claims for payment of any portion of bills for treatment as may be necessary and assign all rights and benefits to WCT Health & Wellness, therefore. You further agree, subject to state and federal law, to pay all costs, attorney fees, expenses, and interest if WCT Health & Wellness takes action to collect payment for services because of your failure to pay all incurred charges in full.

You understand that it is impossible to guarantee the security and confidentiality of information stored on computers or telecommunications equipment connected to the internet. You further understand that it is impossible to guarantee the confidentiality of information being transmitted via email, text, cordless telephones, mobile telephones, or similar telecommunications equipment. You hereby agree to waive legal action against WCT Health & Wellness about the storage or transmission of any confidential information and further hold WCT Health & Wellness harmless for any interception of your medical information resulting from use of the equipment.

By signing this form, you agree that you have read, understand and hereby agree to the above policies and accept responsibility for your account. Further, you consent to treatment by WCT Health & Wellness for yourself and/or **your minor child (Please Write Name & DOB)** _____, including diagnostic evaluation, examination, counseling and therapy, and you confirm that you have the legal right to consent to your child's mental health treatment without the consent of any other individuals. As stated above, this consent shall remain effective until and unless revoked in writing at a later date.

Client Signature and Date_____