POLICIES FOR TREATMENT AND OFFICE PROCEDURES

Please review and initial all lines below.

_____ ITEM 1-CONSENT FOR TREATMENT – I give consent for myself or the client named below to be treated by Veronica Funke, LCSW. If you are 15-17 years of age, you must co-sign. If you are 18 or older, you are responsible for completing necessary paperwork and are given the option of including anyone else to be present during your sessions.

_____ ITEM 2-LEGAL/OFFICE RESTRICTIONS – Parent must be present at the initial session if the client is under 18 years old. Parent may not leave the building while client is in session with therapist if client is under 15 years old. Divorced parents of a minor in treatment must provide a copy of the divorce signed by the court.

_____ ITEM 3-ASSIGNMENT OF INSURANCE BENEFITS/RELEASE OF INFORMATION – I authorize my insurance carrier to pay benefits directly to *Sunrise Psychotherapy* for services provided to me or my insured dependent. I hereby authorize the release of pertinent information required by my insurance to process claims and payment to *Sunrise Psychotherapy*. I understand that I will be held responsible for any unpaid balance after my insurance has been processed.

_____ ITEM 4-FEES/MISSED APPOINTMENTS – The fee for an initial session is $120 and is 60 minutes in duration. Follow ups are $110 and last 45 minutes. Sliding scale is available. If you are using your insurance, you are responsible for any copays prior to your session. Please give 24-hour notice for cancelling appointments. **Less than 24-hour notice will result in a $65 charge**, with the exception of emergency situations.

_____ ITEM 5-TERMINATION OF TREATMENT – Repeated missed appointments may result in termination of treatment. Less than 24-hour cancellation is considered a missed appointment. As a general rule, 3 missed appointments in a 6-month calendar period may result in termination. Also, not following the treatment plan may result in termination. Assault, verbal threats, or inappropriate remarks will result in termination of treatment and you will be responsible for damages. (Firearms/weapons prohibited except a Law Officer.)

_____ ITEM 6-HIPAA NOTICE OF PRIVACY PRACTICES – I have reviewed and understand the Notice of Privacy Practices and have been offered a copy of the Privacy Practices form.

I have indicated my understanding by initialing the above Terms and Conditions for treatment of the client named below.

_____	_____	_____	_____
Printed Client Name	*Client Signature (if 15 years or older)*	*Initials*	*Date*
_____	_____	_____	_____
Legal Guardian Signature	*Relationship to Client*	*Initials*	*Date*