Associated Counseling Group

♦ 748 N MAIN STREET ♦ FREMONT, NE 68025 ♦
♦ 402-941-7016 ♦

Consent to Treatment

*Client Name: _____

Services will involve the following expectations

I, _____, understand that participation / involvement in
(Name of Client/Parent/Guardian for Client)
therapy is expected; I will work on the goals identified through each session or participate as expected and/or discussed with me (or in the case that this is being signed for a minor child/impaired adult, will assist my son/daughter/ward/etc. in working on the goals identified or encourage participation in the therapy sessions.)

_____I give consent to ACG to contact me at (_____)_____-_____ in regard to scheduling needs.
(initial here)

Attendance Policy:

If you are not able to attend a session/participate according to the program's expectations, it is important to reschedule at **least 24** hours in advanced. If you are unable to attend any scheduled session it is your responsibility to call to inform the office that you will not be able to keep your scheduled appointment. We request that you call at **least 24** hours prior to your appointment day and time. Any appointments you fail to call to cancel and you fail to keep will incur a full session fee this fee is not charged to your insurance (if any) it is your responsible for any session fees that may result in the failure to notify of an absence. Same day cancellations may also incur a **full session fee** that is your sole responsibility.

I have read and understand Associated Counseling Group's **Attendance Policy_____ (Please Initial)**

In addition, I (or on behalf of my son/daughter/ward/etc.) agree to the following (when applicable):

- I understand that more than **two (2) consecutive no-shows** (cancellations without a call in advance) could result in a reassignment of the case and/or termination of services (if applicable).
- A session is approximately 45-55 minutes in length and begins at the scheduled session start time. I understand that I need to be on time for all sessions or call prior to session start time if I am unable to be on time. My appointment will be held for me no more than 15 minutes after the scheduled session start time. I am responsible for rescheduling any missed appointments.
- Follow through is expected when referrals are made for any adjunctive treatment that may be deemed important to supplement the current level of service provisions. For example, following through mental status exams or other treatment reviews/recommendations as determined by the funding source or treatment team, psychiatric services for medication evaluations, lab tests to determine the appropriate medication levels, psychological testing as requested, etc. If I (or son/daughter/ward/etc.) refuse to follow the recommendations of my (or son/daughter/ward/etc.) treating professionals, I acknowledge that my (or son/daughter/ward/etc.) involvement with Associated Counseling Group, could be placed at risk and may result in a termination of services.
- I agree to follow the emergency protocol that was explained to me (or son/daughter/ward/etc.) in the rights and responsibilities handout and/or discussed with me by my (or son/daughter/ward/etc.) treating professional.
- I authorize Associated Counseling Group to communicate with _____
  _____
  in regards to confirming appointment times, canceling or rescheduling on my behalf.

Therefore:

I hereby consent to receive the above service(s) and affirm that *the financial obligation is ultimately my responsibility*. I understand I am responsible to identify if precertification is required for the service I am requesting. If precertification is required and I do not inform the office of this condition, I understand the cost of care received outside of certification is my full financial obligation. I understand that until my insurance coverage (if any) is verified, a co-payment of no less than $35 for each session has been set, and I agree to pay this fee prior to my session. I also understand this is not the total cost of my session, and that all efforts will be made to seek primary insurance coverage, however, if for any reason the insurance company, (Medical, Managed Care Medicaid, Third Party Insurance, etc.) does not pay, I agree to accept responsibility for the financial obligation and abide by the terms of this agreement. Furthermore, I agree to allow Associated Counseling Group to bill my insurance company and allow for benefits to be made directly to Associated Counseling Group.

_____/_____

Client Signature Date Parent/Guardian Signature Date

*If for some reason there is a custody change and the said client is a minor, this consent will remain in effect and binding until a new consent is sought.