grace therapy

Consent for Treatment Form

I, _____consent to receive counseling services from

Fani Mwasiti, MSW, LCSW-A the therapist at Grace Therapy. I consent to the terms outlined below:

Available Services: Grace Therapy provides various counseling services including individual, family, or couples counseling. Sessions can be conducted over the phone or via Web-based Video conferencing.

Fee Schedule:

Individual Session (60 minutes) $145.00

Couples or Family Sessions (60 minutes) $160.00

Individual/Couples/Family Session (90 minutes) $185.00

Short session (45 minutes) $130.00

Written Reports: $100.00

(Includes a summary of services and treatment, diagnostic impressions, support letter, etc.)

Cancellation of Appointment: If you are unable to attend an appointment for any reason please call and reschedule giving 24 hour notice. If the appointment is canceled with less than 24 hours' notice or a no-show, you are responsible for paying the full amount of **$130 to $185 late fee.** This fee will need to be paid in full before the next therapy session. Missed and late canceled appointments due to illness, emergency, and inclement weather are exceptions at no fees

Confidentiality: Professional ethics and state and Federal law (HIPPA) require confidentiality of information shared during all medical/mental health sessions. All client files will be kept confidential and only released once you have signed a consent form releasing the information to a specified party.

Insurance: I am currently out of the network, and working to be in-network.

Duty to Report/Duty to Warn/ Duty to Protect: As a licensed clinician I have to report any admission of child abuse or neglect as well as admission of the abuse or neglect of a vulnerable adult. If there is an admission of proposed harm to another individual, I must warn that individual and contact the local police department. If an individual is actively suicidal and unable to contract for safety, I must protect them and will contact safety officials (police, hospital, etc.) If any of these cases arise and law officials must be contacted, please note that your therapist will not receive your written consent to release confidential information.

Consent: By signing this Consent for Treatment Form as the client or guardian of the client, I acknowledge that I have read, understand, and agree to the terms and conditions contained in this form. I have been given the opportunity to address any questions or request clarification for anything unclear. I am voluntarily agreeing to mental health treatment for myself, my child, and/or my family. I also agree to pay all fees associated with receiving counseling services.

_____	_____
Client's Printed Name	**Date**
_____	_____
Client's Signature	**Date**
_____	_____
Client/Spouse/Parent/Guardian Printed Name	**Date**
_____	_____
Client/Spouse/Parent/Guardian Signature	**Date**
_____	_____
Therapist Signature	**Date**

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