PATIENT’S INFORMED CONSENT FOR TREATMENT I have voluntarily chosen to receive therapy services from my therapist at DeLuca Counseling, Inc. I understand that I may terminate treatment at any time. I understand that there is no guarantee that I will feel better or that my issues or concerns may be resolved and that therapy is a cooperative effort between client and therapist. I also understand that during treatment, material or subject matter that may be upsetting in nature to me may be discussed. I understand that confidentiality of records of information about me will be held or released in accordance with state laws regarding confidentiality of such records. I have been informed of my confidentiality and also the limits of it. I understand that if I am utilizing my health insurance to pay for therapy, my therapist may be required to release certain information to the insurance company for claims processing, case management or utilization reviews. I understand I may opt not to utilize insurance to avoid release of any such information and may discuss this option with my therapist. I authorize my insurance company to pay DeLuca Counseling, Inc for services rendered. I understand that I may revoke that consent at any time, except to the extent that treatment has already been provided. I understand that there is a chance I could run into my therapist in a public place. I understand that my therapist will uphold my confidentiality fully by not acknowledging me or approaching me if this were to occur. I understand my therapist will only acknowledge me if I am to initiate contact with my therapist in a public place. I understand that I need to attend all scheduled appointments. If I am unable to keep an appointment, I understand I am obligated to give at least 24 hours notice or else I will be charged a fee. I understand I may be charged fees for any other services rendered outside of regular therapy sessions. I understand that it is my responsibility to determine that insurance will pay for services before they are rendered and that if I do not, I may be responsible for all fees for provided services that my insurance does not cover. I acknowledge that I have read the practice’s PROFESSIONAL DISCLOSURE AND INFORMATION form and understand all items discussed in such. I have read and understand all of the above. Client and/or legal guardian’s

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_