Montana City Counseling

Informed Consent for Services / Rights Acknowledgement:

I hereby request and consent to services for myself which includes therapy, diagnostic assessment, case coordination, consultation, and other treatment/services recommended and considered necessary by *Dr Michael A Emerson - Montana City Counseling*.

I understand that developing a treatment plan with my therapist and regularly reviewing our work toward meeting treatment goals are in my best interest and I agree to play an active role in this process. I understand that no promises have been made to me as to the results of treatment or of any procedures provided by my therapist.

I am aware that I may stop treatment at any time. The only thing I will be responsible for is paying for services already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment (for example, if my treatment has been court ordered, I must answer to the court). I am aware that an agent of my insurance company or other third-party payer may be given information about the type, costs, and dates of any services or treatment I receive through *Dr Michael A Emerson - Montana City Counseling*.

I understand that if payments for the services I receive at this office are not rendered, then *Dr Michael A Emerson - Montana City Counseling* may stop my treatment and may seek collection action to recoup the cost for unpaid sessions.

I have been informed that any information regarding services at Montana City Counseling are subject to release only by my informed and written consent, as indicated under mandated reporting codes, or by subpoena and/or court order.

I have also been informed that identifying information about me may be exchanged between office staff and other designated/contracted providers for continuity of care purposes.

I authorize this office to release any mental health or medical information necessary to process claims for the services provided. I authorize payment of governmental/medical benefits to this office for services provided.

I understand that I remain responsible for all charges not met by my insurance company.
_____ Initials

I agree to enter this therapeutic relationship and to participate in therapy as recommended.

Client Signature_____ Date _____