

MARY PETERSEN, L.M.S.W., A.C.S.W., P.C.
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Consent For Treatment

I _____ with full knowledge of the benefits and consequences of psychotherapy, consent to be treated by Mary Petersen, M.S.W., A.C.S.W., P.C. on a voluntary basis.

I realize that Mary Petersen may employ office staff for minor administrative procedures, billing, filing, and the like, and hence basic identifying information such as client name, address, phone, or even a diagnosis code might be witnessed by such staff who will sign an agreement to keep such information confidential. My signature below indicates my consent for sharing such information with staff.

I agree to take financial responsibility for my sessions at the rate of \$ _____ per 50-minute hour. I will pay for services at the time they are rendered or in advance. Checks will be made payable to Mary Petersen, M.S.W., A.C.S.W., P.C., and they will be made out prior to or during session, not after. I realize that failure to pay for any given session will require me to send payment by mail before the next session, or the next session will not be conducted. Payment may be made by cash, check, credit card or Health Savings Account (HSA) that can be processed via Square. If a check is returned by the bank, I will be charged a \$30.00 fee and thereafter be denied the right to write checks as payment for sessions. If a check does not clear the bank or payment is otherwise not made for one session, another session will not be scheduled.

I am aware that I must give 24-hour notice for cancellations (unless there is a documented emergency) or be charged the full fee. Excessive cancellations or requests for appointment time changes are disruptive to the therapeutic process for the client as well as for the therapist's schedule. Should this become a concern, the therapist reserves the right to terminate treatment for sporadic attendance. I further understand and agree that if treatment is not or cannot be conducted in person that a virtual session (via phone or video) will constitute and function as an in-person session and all guidelines and stipulations apply.

My signature below also indicates that I am familiar with confidentiality and HIPAA privacy regulations, and I understand the information provided in the "client information" sheet given to me. Further, I acknowledge that therapy almost always results in a positive change in the client, although there are no guarantees.

Signature of Client _____ Date _____

Parent/Guardian Signature _____ Date _____

(In case of a minor)

Psychotherapist Signature _____ Date _____