INFORMED CONSENT

Today's Date: _____/_____/_____

Client Name ___________________________________ Date of Birth: ______________

Contact Phone #:______________________Ok to leave message on this phone? Y N

CONTACT AND EMERGENCIES

You may contact us by phone at (512) 572-9217 and leave a message on our confidential voicemail. These messages are checked daily, but please note that this is not an emergency phone number. If you have an emergency or need immediate assistance, please contact 911 or the 24-hour crisis hotline at (512) 472-HELP (4357). For additional resources, 211 is available. Therapists may be reachable by email or text, but please limit this contact to logistical and scheduling purposes.

FEES FOR SERVICES

Austin Vitality Counseling will bill Medicare for our psychotherapy services. The client may be responsible for co-pays, co-insurance or deductibles. Payment , if required, is expected at each session and can be made by cash, check or credit card. 24-Hour's notice is required to cancel a session, or a $50 fee may be charged. If we are not billing your insurance, our fee for a 55-minute session or consultation is $125.

ASSIGNMENT OF BENEFITS

By signing below, you are authorizing the release of necessary information about your care to your primary and, if applicable, secondary insurance to process your insurance claim. You are also assigning benefits to Austin Vitality Counseling for any eligible payments from your insurance carrier. This is a direct assignment of the rights and benefits under the insurance policy. Your signature below will serve as a signature on file and may be revoked in writing at any time.

CONSENT TO TREATMENT

I authorize and request that Austin Vitality Counseling provide in-home psychotherapy, or in some cases telehealth via a HIPAA compliant video conferencing application. The frequency and best course of treatment will be decided between my therapist and me. I understand that the purpose of these procedures will be explained to me and be subject to my verbal agreement. I understand that there is an expectation that I will benefit from psychotherapy but there is no guarantee that this will occur. I understand the limits of confidentiality regarding my treatment. Those limits have been described to me as: if I am a danger to myself or others, in child or adult abuse cases and/or if there is a subpoena for records by a court of law. I have read and fully understand this form.

Client Signature: ____________________________________ Date: _____/_____/_____