Core Health
COUNSELING

Consent For Treatment Form

I, _____ consent to receive counseling services from Melissa Gordon-Pitts, LCSW-C, LCSW, therapist at Core Health Counseling. I consent to the terms outlined below:

Available Services: Core Health Counseling provides an array of counseling services including: individual, family or couples counseling. Sessions can be conducted in person, over the phone or via Web based Video conferencing.

Fee Schedule:

Individual Session in person (60 minutes) $125.00

Couples or Family Sessions in person (60 minutes) $135.00

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

Phone Session (30 minutes) $50.00 (60 minutes) $75.00

Web Based Video Conferencing (30 minutes) $60.00 (60 minutes) $85.00

Professional Meetings: $125.00 per hour

(Includes In-Patient Hospital Visits, Court, Meetings with Attorney within 20 miles of office. If more than 20 miles from office $5.00 per mile.)

Written Reports: $100.00

(Includes summary of services and treatment, diagnostic impressions, court reports etc.)

Cancellation of Appointment: If you are unable to attend an appointment for any reason please call and cancel giving 24 hour notice. If the appointment is cancelled with less than 24 hour notice you be responsible for paying a $75.00 late cancel fee. This fee will need to be paid in full before the next therapy session.

Confidentiality: Professional ethics, 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.

Duty to Report/Duty to Warn/ Duty to Protect: As a licensed clinician I have a duty 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 have the duty to warn that individual and contact the local police department. If an individual is actively suicidal and unable to contract for safety, I have a duty to protect 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 and/or request clarification for anything that is unclear. I am voluntarily agreeing to mental health treatment for myself, child and/or 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