Susan Dellutri, LLC
Consent for Treatment

Welcome. Before therapy can begin, your signature(s) will be required on this informed consent document. **Please read carefully, initial each paragraph and sign at the bottom.**

______I authorize Susan Dellutri, LLC and Therapies East Associates, LLP to release to my insurance company any information from my medical records which maybe necessary to determine benefits and receive payments directly. **I understand that I am financially responsible for all charges not covered by my insurance plan and any costs associated with collection activities, legal fees, accounting and other related activities required to secure that payment.**

______Therapy sessions will be billed at $210 for an initial evaluation and $140/$160 for 45/60 minute individual therapy and $180 for couple and family sessions. **Additional services (phone calls longer than 15 minutes, collateral meetings, writing letters or treatment summaries) will be billed at $100.00 per hour and are the client's responsibility.**

______**Missed appointments and sessions cancelled with less than 24 hours notice may be billed at $80.00**, and are not reimbursed by insurance.

______All client information and case records will be maintained in the strictest confidence under law. No information will be released without client signed consent. If you would like to review your records, notify your therapist. The following exceptions apply in accordance with State and Federal laws: 1) court order compelling disclosure; 2) disclosure and action when there is reason to believe that a client is threatening to harm self or another person; 3) disclosure and action when there is reason to believe a child or vulnerable adult has been abused or neglected.

______If you are being seen as a couple or family, in order to help you strengthen relationships within your family, it is important that the therapist not receive information that must be kept secret from other family members.

______I have been provided a copy of the Notice of Privacy Practices (HIPPA) for review. I understand copies are available, either in the office or on the clinic website: www.TherapiesEast.com

______Electronic communication is limited to administrative business. All other uses will be determined by the therapist, with additional consent. Recording of sessions is prohibited without permission from all parties.

______Some clients may experience increased distress when problems are first disclosed, but therapy outcomes are usually positive. Negative effects are rare. Treatment plans will be developed collaboratively to help you reach your goals. If you wish to file a grievance, you may speak to the privacy officer, Lila Piraino (414) 278-7980 X112

I consent to voluntary treatment for myself and/or minor child/ward which may include individual, couples, or family therapy in which the treatment plan and treatment will be developed in collaboration with me.

This consent is valid for the entire course of treatment and may be withdrawn, in writing, at any time.

Client(s) signature____ Date_____________________

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Therapist signature ____ Date_____________________