Therapies East Associates, LLP, 827 N. Cass Street, Milwaukee, WI 53202

I am voluntarily seeking services with _____for myself (name)_____

Or my minor child/ward named _____beginning _____

Consent to Treatment

I understand that:

1. I have responsibility in the development of my own or my child's treatment plan. The treatment shall be developed with my understanding and approval.
2. one of my rights is the right to specific, complete and accurate information concerning the purpose of treatment, including the benefits and side effects of treatment.
3. I may request the opinion of a consultant or be given information concerning alternatives for treatment.
4. termination is usually an agreement between my therapist and myself, but I have the freedom to discontinue treatment at any time.
5. this consent shall be valid from the date specified above until termination of therapy.
6. my clinical information is confidential in accordance with the accompanying HIPPA agreement.
7. material concerning my rights and responsibilities, the "DHSS Patient Rights" brochure, is available in the waiting room areas.
8. confidential consultation between my therapist and the Therapies East Associates, LLP staff and their consulting psychiatrist will occur as deemed necessary.

Fee Agreement

I agree that:

1. _____ charge for services is $_____ per hour.
2. my insurance will be billed at this rate if I choose to use my insurance to cover fee for services.
3. I shall be **responsible for any charges not covered by insurance plans**. If I do not choose to use/authorize the billing of my insurance company, I will be responsible for the full cost of services. If the above hourly fee creates a hardship for me, it is my responsibility to request a payment agreement that will be suitable for my current financial situation.
4. any and all costs associated with collection activities, legal fees, accounting and other related activities required to secure payment will be my responsibility.
5. my **deductible and/or co-payment fees will be collected at each appointment**.
6. telephone conversations with my therapist lasting longer than 15 minutes may be billed at a partial hourly fee thereafter. This fee is not covered by insurance. I will be informed at the time of the call if fees are being charged.
7. any additional services requested by a client for any reason will be billed as a separate charge. For example, all correspondence/phone calls requested by a client will be billed at a $_____/hour rate. These additional services include sending a letter, treatment summary, etc. to courts, attorneys, state agencies, probation officers, etc. and all other service time not covered by insurance.
8. I will keep scheduled appointments or I will give a minimum of **a 24-hour notice of cancellation.** Failure to abide by this notice may result in my being billed $_____ for my session. (Insurance coverage does not apply).

Client Name (Please print) _____Adult Signature (For minor child) _____

Client Signature _____Relationship to Child_____

Date _____