

**DOCUMENTATION OF
PATIENT'S INFORMED CONSENT FOR TREATMENT**

Your first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some initial impressions of what your work may include. You should evaluate this information along with your own assessment about whether you feel comfortable working with me.

I understand that we will begin with an evaluation of my needs, and that my therapist is not obligated to accept a referral. I understand that psychotherapy is not an exact science, and that no guarantees are being made as to the result or evaluation of my treatment. As a participant in my treatment, I share the responsibility for the process, including goal setting and termination. I understand that, through the process of treatment, I may be working toward changes which may cause me to experience many different and intense feelings, some of which may be painful. Also, I understand that when I make changes in myself, I may experience changes in other areas of my life (i.e. family, work, social life, etc.). I am aware that every change potentially has both positive and negative effects, and that an important part of treatment will be to clarify and evaluate potential effects of changes before undertaking them.

I understand that therapy involves a large commitment of time, money, and energy, and that therefore it is important to select a therapist carefully. I know that if I have any questions about my therapist's policies or procedures, I can discuss them whenever they arise and that, if I request it, my therapist will help me to secure an appropriate consultation with another mental health professional.

I agree that I am personally responsible for the payment of any balance remaining on my account after payment toward said account by my insurance company. In the event that there is no insurance coverage or if for any reason my insurance company refuses to pay any charges reflected on my account, I agree that I am personally responsible for the entire amount of my account. I understand that I will be billed for a missed session if not canceled or rescheduled **24 hours** prior to the appointment time and that my insurance company will not pay for any missed sessions or telephone contacts. I am aware that Gwyn, from this office will file claims with my insurance company and handle all other billing. If my account becomes delinquent for a period of 90 days, I understand that a collection agency may be contacted to obtain the full balance and that this will necessitate providing the agency with information necessary to recover the balance. If my account becomes assigned to a collection agency, I agree to pay all costs of collections including agency and attorney fees.

By signing below, I agree to begin treatment, and accept responsibility for payment for services provided. I have read about the potential limits of confidentiality as described on the sheet entitled **PRIVACY & CONFIDENTIALITY** including those imposed by Williamsburg Centre For Therapy's office policies and by state law and I understand the policies described on the **PATIENT INFORMATION** sheet. I accept these as conditions of receiving psychological services. I understand that I can discuss these or any other concerns with my therapist at any time.

(Signed) _____ Date _____

**DOCUMENTATION OF
PATIENT'S INFORMED CONSENT FOR RELEASE OF INFORMATION
TO OBTAIN REIMBURSEMENT FROM A THIRD PARTY PAYOR**

I hereby authorize the release of the information necessary to process insurance claims. I request that payment be sent directly to Williamsburg Centre For Therapy of benefits otherwise payable to me.

Patient Signature (or guarantor) _____ Date _____

I UNDERSTAND THAT MY INSURANCE COMPANY WILL NOT PAY FOR SESSIONS THAT ARE MISSED OR NOT CANCELLED WITHIN 24 HOURS OF MY SCHEDULED APPOINTMENT TIME AND THAT I WILL BE HELD FINANCIALLY RESPONSIBLE FOR THE FULL AMOUNT OF SAID SESSION. _____ Initial

You have the right to revoke this consent in writing. Any actions that WCFT has taken on your behalf before your written revocation of this consent would not be covered by said revocation. _____ Initial