Live Oaks Counseling
5815 W William Cannon, Suite 105
Austin, Texas 78749
phone: 512-960-4477

Informed Consent for Treatment

My signature below serves as acknowledgement of my consent to treatment. I understand that no promises have been made with regard to the outcome of my treatment. I further understand that I may cease treatment with this therapist at any time. However, If I stop treatment, I will remain responsible for any unpaid balances for treatment I have already received.

I understand that the rate for my services with Live Oaks Counseling will be $_____ for the first assessment session and $_____ for each subsequent session. The time allotted to my sessions will be determined by the therapist based upon the context of my treatment. My therapist will discuss the time allowed for subsequent sessions with me at the initial assessment. In general, most sessions are between 45-60 minutes, however, certain situations made dictate a longer session. The rate charged per session will depend on the time allotment.

I agree to call to cancel an appointment at least 24 hours before the time of the appointment. If I fail to cancel within the 24 hours I will be charged a late fee. If I fail to show up for a scheduled appointment, I will be charged the full fee.

In an effort to protect the integrity of the client and therapist relationship it is never recommended that the therapist appear in court on behalf of a client. however, it does sometimes become necessary for a therapist to appear in court at the request of a client or an attorney. If my therapist is required to go to court or write a report on my behalf, I agree to compensate the therapist at the rate of $_____ per hour or $_____ per day.

If I am insured, I am aware that my insurance company will be given information about the type(s), costs and providers of services that I receive. If payment for the therapist's services is not made, I will be billed for those services and the therapist may stop my treatment if those services billed remain unpaid.

The therapist will maintain strict confidentiality regarding information obtained in the sessions with client. However, there are situations in which confidentiality must be broken as required by the Licensing Board for the therapist's profession. If a client informs the therapist that a child or elderly person is being abused or the client intends to harm self or others, the therapist must abide by the regulations of the profession and take appropriate action. Additionally, if a court orders the therapist to divulge information obtained during sessions, the therapist must do so.

I understand that the therapists at Live Oaks Counseling will staff cases with other therapists at Live Oaks Counseling and that they may receive input and support in these meetings. Every effort will be made to protect my privacy and my information will not be discussed outside of staff meetings.

My signature below indicates that I have had an opportunity to read these statements and to discuss them with my therapist. I further understand that this acknowledgement will be kept by the therapist and become part of my medical record. I may be given a copy of this acknowledgement if I so request.

_____	_____
Signature of client or responsible party	Date
_____	_____
Printed name	Relationship to client