

Client Consent / Acknowledgements

Client Name: _____

Included in your Welcome Brochure are copies of your *Rights & Responsibilities*, *Privacy Policy* and *Grievance Procedure*. Keep them for future reference. Before the first session, please review the items below and **INITIAL** in the appropriate box. **THIS FORM IS TO BE COMPLETED IN FRONT OF A WITNESS.**

Initial

	• I have received a copy of and understand the "Client Rights & Responsibilities."
	• I have received a copy of and understand the "Notice of Privacy Practices".
	• I have received a copy of and understand the "Grievance Procedure."
	• I certify that all information given is true and complete to the best of my knowledge.
	• I give my consent to James Gagnon Ph.D, LCSW to provide psychotherapeutic treatment and therapy necessary or advisable for me or my child's overall well-being.
	• I understand that I may stop treatment at any time.
	• I acknowledge that my therapist has reviewed her qualifications with me.
	• I have been informed about and understand the emergency procedures to be used during the agency's non-business hours.
	• In the case of an emergency, I authorize James Gagnon to contact the person I designated.
	• I understand that my therapist has set aside time exclusively for my use therefore I agree to cancel appointments at least 24 hours in advance.
	• I understand that I may be charged for late cancellations (less than 24 hours) and for no shows. This fee is ½ the established fee for sliding scale clients, or the co-pay / deductible amount for insurance clients.
	• I understand that I will be considered a no-show and may be rescheduled if I arrive over 15 minutes late.
	• I understand that payment is due at the time of the appointment unless I make arrangements for a delayed schedule of payment.
	• I agree to notify the agency of any changes to my income and/or insurance.
	• I have been informed that the agency charges a fee for services and that I am responsible for payment based on the following selection: (*please initial by ONE option below)
	• I agree to pay James Gagnon Ph.D., LCSW \$135 for initial session and \$90 a session there after
	• The co-pay / deductible as required by my health insurance coverage; or EAP <ul style="list-style-type: none"> ○ I authorize the release of any medical or other information necessary to process insurance claims. ○ I authorize payment of medical benefits to the assigned supplier of services. ○ I authorize that this claim may be filed electronically. ○ I authorize that TGH Billing may file this claim.

The signature below acknowledges that I have reviewed the above with the client.

Client's / Parent's / Guardian's Signature_____
Date_____
James Gagnon Ph.D., LCSW_____
Date