

# Aspire Counseling Group, PLLC



1405 Hillsborough Street

Raleigh, NC 27605

www.AspireGroupNC.com

919-229-9834 office • 919-747-4269 fax

## Consent for Services

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### Appointments, Cancellations, and Fees

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Sessions will normally occur once per week; they may become less frequent as treatment nears the end. Unless otherwise arranged, sessions will be approximately 45 to 50 minutes in length and will begin and end promptly.

Please provide 24-hours notice if you must cancel an appointment. If notification is not given, the client will be responsible for payment of \$45 to cover the missed session; this \$45 fee is not reimbursable by any insurance company. Payment is expected at time of service. A \$25 fee will be charged for any returned checks. You are responsible for all charges incurred during the course of treatment.

If your therapist is subpoenaed or otherwise required to appear at a deposition, trial, or other legal proceeding, you will be charged an hourly rate of \$100 for all time spent by your therapist preparing for testimony, writing reports, and travelling to and attending the proceeding.

### Confidentiality

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The relationship between a therapist and client is a confidential one. Information will only be released to others with your written permission, with a few exceptions. In special circumstances where the client is a danger to self and/or others, the therapist is required by law to disclose this information to authorities without written consent. Also, in circumstances where child abuse or elder abuse is suspected, the therapist must tell authorities. (See "Notice of Privacy Practices" for more specific information about confidentiality, your rights, and access to your records.)

### Insurance and Payment

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Services provided are covered under many health insurance plans. Mental health benefits vary widely from plan to plan, and you should review your health insurance policy carefully to be aware of the limitations of your coverage. It is your responsibility to know what your insurance benefits are, whether you are using in-network or out-of-network benefits, and any limitations to your coverage.

Please note that without your signature on this form the therapist will **not**, because of confidentiality, release medical information to your insurance company and cannot, therefore, file insurance claims for you.

### Commitment to Quality Treatment/Client Rights

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Your therapist works from a variety of treatment perspectives and is committed to providing quality professional services. Your personal history, circumstances, beliefs, and values will be incorporated into and respected in treatment. You have the right to ask questions at any time about your therapy. You also have the right to review your records at any time and to get copies for other professionals to use. In addition, you have the right to revoke this consent in writing at any time. Actions taken prior to the revocation of the consent are *not* subject to revocation.

Your signature indicates that you have read and agreed to the conditions stated above and that you voluntarily consent to receive psychotherapy services.

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Client signature

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Date

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Parent/Guardian signature if client under 18 years of age

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Date

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Therapist signature

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Date