

On Purpose Counseling Services LLC 405 East Forest Street, Suite 119 Oconomowoc, WI 53066

CONSENT FOR TREATMENT

Client Name:		Client DOB:	

Payment Policy

Payment is required at the time of service. Payment options include, cash, checks and credit cards (Visa, MasterCard, Discover, American Express, Debit Cards processed as Credit and HSA/FSA/MSA Cards). Other payment options, such as sliding fee scale arrangements based upon your income, should be discussed prior to your first appointment. Please be prepared to make your payment at the beginning of each session. COLLECTIONS: Past due accounts will be turned over to our collection agency/attorney. All fees incurred by this action will be the responsibility of the client.

Rates/Fees

Initial Appointment (Intake – 60-90 minutes): \$200 Follow-up Appointment(s) (45-60 minutes): \$150

Late Cancelled Appointments and Failure to Show for an Appointment

My policy requires 24 hours notice for cancellation of any appointment. You may call and leave a message on voicemail, which will time stamp the call. If cancellation of an appointment is not received on time, the full fee will be charged. An invoice for payment will be emailed to you, payment of which is due before your next scheduled appointment. Failure to show up for a scheduled appointment will result in the same charge and process for billing and may be cause for termination of services.

Clients Rights and Confidentiality

Your treatment and care will be kept confidential. I acknowledge that I have received a copy of and have read On Purpose Counseling Services, LLC's "Client Therapist Agreement" and "HIPAA Notice of Privacy Practices". I have been made aware of how my Personal Health Information may be used and disclosed. Information about you will only be released with your written consent, except in situations that are required by law or in cases in which you have been referred or ordered by the Court. By law, I must release information in situations of: (1) abuse or neglect of children; (2) abuse or neglect of the elderly; or (3) cases of probable suicide or homicide. In these cases, your provider may need to take steps to protect people from harm or to warn them such as: (1) contacting a family member; (2) contacting a public agency; or (3) arranging for hospitalization.

Referrals

I may deem it appropriate to make a referral to another practitioner for specific services. Referrals will be made to known professionals in the field and in related fields. Knowledge as to their competence comes in part from reports from other patients, and thus, we cannot take personal responsibility for their competence.

Emergencies

On Purpose Counseling Services, LLC is not available in an emergency. If you need immediate help, please dial 911, or go to your nearest emergency room or local hospital for evaluation. Please see Emergency Contact Information Sheet for more information.

Telephone Calls/Texts/Email

Phone messages will be returned as soon as possible. There will be no charge for, brief, return phone calls and/or emails. Text messages and email will be accepted for scheduling *only*. I understand that by utilize varying forms of social media, including email and texts, to communicate, I decrease the confidentiality of my personal health information.

Consent for Treatment

I request and authorize On Purpose Counseling Services, LLC to provide and perform counseling, therapy, coaching, consulting and other psychological-based interventions which are considered advisable for my health and well being. I understand that Alexander Luber will request my participation in developing my plan for treatment including informing me of the benefits and expected outcomes for treatment, the type of treatment, and alternative options and problems that may arise if I don't receive treatment. I further understand that On Purpose Counseling Services, LLC cannot guarantee the outcome of the treatment provided.

I have received a copy of and have been informed of the policy on confidentiality and client's rights. I have read and understand the above information. I understand that this consent for treatment is good for no longer than 15 months and may be revoked by me at any time by written notice to my treating provider. I further understand that I am responsible for any costs incurred prior to the revocation of the consent for treatment and that any information released by my consent prior to revocation of consent for treatment cannot be retrieved. I hereby consent to treatment.

Signature of Client/Parent/Legal Guardian	Date
Signature of Witness	Date