Consent to Treatment
Statement of Understanding

By initialing each statement below and signing the bottom of this form, I attest that I am in agreement with the statements on this form. This consent/statement of understanding will be in effect for the length of the treatment.

____I willingly give my consent to receive service at Envision Counseling.

____I attest that I and/or my dependents have insurance coverage with_____ and I give permission for Envision Counseling to bill my insurance and obtain any information needed applicable for my treatment OR_____ I do not have insurance and will be paying for any received service out of pocket.

____I understand that I am financially responsible for my balance and that payments are due at time of service.

____I understand that if I fail to give 24 hours notice/miss a scheduled appointment, I will be billed for half the amount of the session. In accordance with Medicaid rules, clients insured by Medicaid are not required to pay for missed sessions; however upon not showing for scheduled appointments or failing to give 24 hours notice, they will lose the privilege of scheduling appointments in advance.

____If I am required to appear as a witness, the party responsible for my participation agrees to reimburse at the rate of 125.00 per hour for time spent traveling, preparing reports, testifying, being in attendance and any other case related costs. You will also be charged .75 cents per mile for travel to and from my court appearance.

Client Name (print)_____

Signature_____Date_____

Legal Guardian (if applicable) (print)_____

Signature_____Date_____

If you would like a copy of this agreement, please let us know.