Belleville Counseling Associates Counselor: 5 Executive Woods Ct., Lower Level Swansea. Illinois 62226 **Consent to Treatment** I acknowledge that I have received, have read (or have had explained to me), and understand the information about the therapy I am considering. I have had all my questions answered fully. I do hereby seek and consent to take part in the treatment by _ , MSW, LCSW. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process. I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist. I am aware that I may stop my treatment with this therapist at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.) I know that I must call to cancel an appointment at least 24 hours before the time of the appointment. If I do not cancel or do not show up, I will be charged a \$50.00 cancellation fee. I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive. understand that if payment for the services I receive here is not made, the therapist may stop my treatment. My signature below shows that I understand and agree with all of these statements. Signature of client (or person acting for client) Date Printed name Relationship to client (if necessary) Agreement to Pay for Professional Services ______ request that _____, MSW, LCSW provide professional services to me I understand that the standard fee for individual therapy is \$150.00 per hour but may be negotiated based upon my income and ability to pay. My therapist and I have agreed upon a rate of My insurance provider is _____ and I have a co-pay payment of \$_____ I understand that my signature below also signifies my authorization to release information to my insurance company necessary to proceed with billing for services rendered. I am aware that my payments need to remain current. To avoid getting behind on my bill I understand that I should make every attempt on maintaining the agreed upon fee. If my payments fall behind I will need to wait to schedule a follow up appointment pending the ability to bring my account up to date. I agree that this financial relationship with this therapist will continue as long as the therapist provides services or until I inform her, in person or by certified mail that I intend to end therapy. I agree to meet with this therapist at least once before stopping therapy. I agree to pay for services provided to me (or this client) up until the time I end the relationship. I agree that I am responsible for the charges for services provided by this therapist to me (or this client),

although other persons or insurance companies may make payments on my (or this client's) account.

Signature of client (or person acting for client)	Date
Printed name	

I, the therapist, have discussed the issues above with the client (and/or the person acting for the client). My observations of the person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

Signature of therapist	Date	

#5 Executive Woods Ct., Lower Level Swansea, Illinois 62226

Client Information Form 1	lient Information Form 1 Today's date:			
Identification				
	DOBSocial Secu	ıritv #:		
	State:Zi			
•	Can we leave a message at this n			
= :	Can we leave a message at this nu			
	ppointments at cell number?YES N			
	mpany: (Verizon, AT&T, T-Mobile, etc.):			
Do you agree to reminders/messag	ges on your email?YESNO			
Email address:				
		Occupation:		
Address:				
Street Suite	•	tate Zip		
Work phone:	Can we leave a message at t	his number? YES NO		
Spouse:	Emergency Contact:	1		
Address if different than above:		Apt.:		
City:	State:Zi	p:		
Home/evening phone:	Can we leave a message at this number?	Can we leave a message at this number? YES NOWork Phone:		
Payment Information				
Responsible Party:	Relationship to the	e Client:		
Address if different than above:		Apt.:		
	State:Zi	p:		
Insurance Information				
Insurance Company	Subscriber No.	Policy No.		
Primary Policy Holder Name	Social Security Number	Date of Birth		
Billing Address	Phone	Contact		
Secondary Insurance Company	Subscriber No.	Policy No.		
Billing Address	Phone	Contact		
Referral: Who gave you my nam				
Name:	Phone:			
Address:				
	this person for the referral? • Yes • No ght be of help to you?			
Client Signature		Date		
Chent Signature		Dale		

W Belleville Counseling Associates #5 Executive Woods Ct., Lower Level Swansea, Illinois 62226

Brief Health Information Form

A. Identification Client's name:		Case #:	Date:	
		nterfering with your current icant adult or childhood illn		to include any
Age Illne	ess/diagnosis	Treatment received	Treated by	Result
2. Describe any aller				
To what?		on you have	Allergy medications y	ou take
others.		r have taken in the last ye Taken for	Prescribed and	
C. What are your prim	ary reasons for seekii	ng counseling?		
Primary Care Physician (Name, address & Pho		e check the appropriate b	oox below:	
	May I I	May I have your permission to inform him/her of your involvement in counseling? • Yes • No May I have your permission to discuss with your physician any treatment concerns, evaluations, needs and/or progress? • Yes• No		
Client Signature			Date	