

**Marci Payne, MA, LPC**  
**Informed Consent**

**Therapy:** *This therapist coaches from a systems perspective with the theory that problems are co-created within the family, relationship, and/or organizational system. I consent to the counseling/consultation process with this therapist. I understand there are no guarantee's made to me regarding counseling. This therapist's approach is one of many treatment options available.*  
**Services not offered:** **sexual abuse investigations, custody evaluations, disability assessments, legal testimony.**

**Confidentiality:** All information shared in session is confidential except in circumstances governed by the law, including the mandatory reporting of alleged harm to self or others, particularly in the case of child, disabled person, or elder abuse. All medical records releases require prior authorization. There is a fee for copies and preparation, not covered by insurance plans.

**No Suicide Agreement:** I agree not to attempt or otherwise engage in self harm and/or harm to others. I agree to seek hospital/emergent care in the event I might violate this agreement.

**Minor Children:** If a minor child (age 13 and up) is requesting counseling, my family's therapist will work with the parents as much as the teen. Clients under the age of 18 may not cancel or change appointments. *Divorced Parents: In joint custody, both parent signatures are required on consent..*

**Client Discharge:** I understand that I may discontinue service at any time. My therapist may also discontinue service at any time with or without my consent for non-compliance, non payment, excessive missed appointments. I will be given a referral for another provider upon request.

**Fees:** Sessions are 50 minutes unless otherwise agreed upon. This therapist charges **\$90 for individual sessions and \$100 for couples/family session.** Fees are re-evaluated and subject to change. Fees not covered by my insurance company will be my responsibility: *phone calls over 10 minutes (\$2/minute), report/letter writing, missed appointments, record requests, bank charges for insufficient funds.*

**Payment Options:** Payment (or co-payment, co-insurance, deductible) for services are **due at the time of service.** This therapist accepts cash, check, and credit/debit/HRA card for payments. (See pre-authorized credit card form on back of this form for other payment options.)

**Collections:** Using the pre-authorized credit card payment form will prevent my account from being sent to a collection agency. Otherwise, accounts with excessive unpaid balances are sent to collections when no payment is received within 90 days of discharge. If an account balance is forwarded to a collection agency, I understand that I and/or my immediate family members will not be accepted as a client in the future. (Invoices are mailed monthly, so will have multiple chances to pay.)

**Insurance:** At this time, this therapist accepts most (but not all) insurance and EAP payments for approved services. Clients are responsible for obtaining authorizations, when required by their insurance company. A copy of my insurance card is required at the first appointment. Clients are responsible for filing their own secondary insurance plan, when applicable.

**More on Back – Signatures Needed**

**24-Hour Cancellation Policy:** If I miss a session without canceling, or cancel with less than 24 hour notice, I will be charged a \$30 missed appointment fee. I understand that this fee is collected via pre-authorized credit/debit card payment. I will receive a letter letting me know that I missed my appointment and that my credit card was charged. *When 24-hour advance notice is not possible, I will be charged \$30 unless I reschedule/attend appointment within 6 calendar days.*

### Informed Consent Signatures

My signature is my consent that I have: read these statements, had sufficient time to consider it carefully, asked any questions that I needed to, and understand it.

_____		_____	
Print Client Name		Date of Birth	
_____	_____	_____	_____
Client Signature	Date	Therapist/Witness Signature	Date
_____	_____	_____	_____
Parent/Guardian Signature	Date	Parent/Guardian Signature	Date

### Pre-Authorization for Credit Card Payments

I authorize \_\_\_\_\_ (Therapist Name)

to keep my signature on file and to charge my account for (please initial):

1. Outstanding Balances:  
\_\_\_\_\_ Balances not paid by insurance/myself within 90 days
2. Missed Appointment Fees:  
\_\_\_\_\_ \$30 each missed appointment

I understand I will receive a letter or invoice notifying me of the charges made to my credit card. This authorization is valid for 1 year unless I cancel the authorization through written notice.

Card Holders Name: \_\_\_\_\_

\_\_\_\_\_ Visa \_\_\_\_\_ MasterCard \_\_\_\_\_ Other ( \_\_\_\_\_ )

Account # \_\_\_\_\_

Expiration Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ CVV Code \_\_\_\_\_

Signature \_\_\_\_\_ Today's Date \_\_\_\_\_