CONSENT TO MENTAL HEALTH TREATMENT & Financial Agreement

Client Name: _____ Date of Birth: _____

Consent: I, _____(name of parent, if child above) the undersigned, hereby **attest** that I have voluntarily entered into treatment (or give my consent for the minor or person under my legal guardianship mentioned above to enter into treatment) with **Stefanie M. Brown, dba PTSD Trauma Treatment Center**, hereafter referred to as Stefanie M. Brown. Further, I consent to have treatment provided by this counselor. The rights, risks, and benefits associated with the treatment have been explained to me. I understand that the therapy may be discontinued at any time by either party. Stefanie M. Brown encourages that I discuss discharge decisions with her as the treating psychotherapist in order to better ensure that an appropriate plan for discharge can be facilitated.

Non-voluntarily Discharge from Treatment: A client may be terminated from treatment non-voluntarily if: (A) the client exhibits physical violence, verbal abuse, menacing behavior, or engages in illegal acts at the clinic, (B) the client refuses to comply with stipulated program rules, refuses to comply with treatment recommendations, or does not make payment or payment arrangements in a timely manner (within 10 days of invoice), (C) the client has 3 no show/no calls and/or late cancelations over a period of 6 session; and/or (D) Stefanie M. Brown determines—for any reason—that continued treatment together is not in the best interest of all, or any, involved. The client will be notified of the non-voluntary discharge by letter and referrals to other clinicians will be made. The client may appeal this decision with Stefanie M. Brown or request to reapply for services at a later date—which may or may not be granted.

Financial Agreement: If you have Tricare, Aetna, Cofinity, or Cigna, Stefanie M. Brown will accept payment in the amount predetermined by contract directly from those payors. **By signing below**, **you give** Stefanie M. Brown permission to disclose to your carrier or plan enough confidential information, sometimes to include, for example (but not necessarily limited to): your name, date of birth, social security number, diagnosis, and treatment plan, to ensure proper payment. In addition, **by signing below, you agree** to be responsible for any copay, any deductible, any uncovered or denied services (some that are usually not covered are noted below). Except where insurance differs, or otherwise agreed in writing signed by Stefanie M. Brown, **you agree to** the following (**please initial each line item**):

____ 90791 Initial consultation\	$ 150 (55-75 min)
____ 90847/46 Family/couples' counseling	$ 130 (55 min)
____ 90834 Individual counseling	$ 85 (45 min)
____ 90837 Individual counseling	$ 100 (55 min)
____ Extensive phone consultation (*more than 5 minutes more than once a month*) / correspondence and/or report writing (e.g. VA, SSI) / record production (or summary of records – at provider's discretion)	$ 100/hr prorated *(not covered by insurance)*
____ Report writing for court proceeding, conferring with attorneys or anyone else related to court proceedings (including other therapists), preparation for testimony, testimony at hearing, deposition, or trial (including time blocked to be available to testify)	$ 200/hr prorated *(not covered by insurance)*
____ **No show or cancellation with less than 48-hour notice**	**$ 40 *(not covered by insurance)***
____ Equine-Assisted Psychotherapy (if available) (90 min)	$ 150 *(might not be covered by insurance)*

Based on information provided by your insurance company, your deductible ___ is met / ___ is not met / or ___ is not known. Your portion of the fee at the time of service is estimated to be:

Initial consultation: $_____ *(this is an estimate only, **you agree** to pay the final amount*)

Follow up sessions: $_____ *(this is an estimate only, **you agree** to pay the final amount)*

I consent to mental health treatment (for myself and/or for those on whose behalf I am signing) and **I agree to** abide by the above-stated financial policies and agreements with Stefanie M. Brown dba PTSD Trauma Treatment Center.

_____ _____ _____

Signature of Client (or Parent/Guardian) (Printed Name of Person Signing) Date

_____ _____

Witness Date