Family Services OF THE MERRIMACK VALLEY

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TREATMENT AGREEMENT

1. CONSENT TO TREATMENT: I,_____, consent to become a client of Family Services and to receive counseling services. I understand I have the right to ask questions about procedures used and I can end services at any time. My counselor and I will mutually develop plans for my treatment.

2. FEE AGREEMENT: The cost for 45-50 minutes of counseling is $115.00. Service can be paid for with a combination of insurance, my out-of-pocket payment and United Way subsidy, which is available for 15 hours of service per year. **There is no United Way subsidy in the event of third-party mandated treatment.**

No service can be given if I have an unpaid balance unless specific written arrangements have been made and approved by the Clinical Director.

(To be completed if client has insurance) My co-pay is $_____. I agree to pay for service when rendered.
(To be completed if client is self pay) My out-of-pocket fee is $_____. I agree to pay for service when rendered.

3. CANCELLATION: Family Service requires 24 hours notice if appointments are cancelled. To cancel an appointment after business hours or during weekends and holidays, I know I can call Family Service and leave a message on my counselor's voice mail. I understand my insurance cannot be billed for a missed appointment.

4. TERMINATION OF TREATMENT: Regular attendance at counseling is important for progress to occur. I understand if I miss 2 appointments (no-show or cancel without 24 hours notice) that treatment will end. If this happens, my counselor will provide me with a list of other treatment providers. I know that I am not eligible to reapply for treatment at Family Service 90 days from the last missed appointment.

5. PRIVACY: I have been given the Privacy Notice packet. I understand that information I reveal to my counselor is confidential. Exceptions to my confidentiality are described in the Privacy Notice and the attached "Facts About Professional Confidentiality", which I received. Questions that I have about confidentiality have been discussed with my counselor.

6. HIV/AIDS: I have been provided with information about HIV/AIDS.

*Client's Signature*_____Date_____
*Parent or Guardian*_____Date_____
*Counselor*_____Date _____

7**. INSURANCE INFORMATION**: I understand that my insurance carrier will be contacted to verify the status of my policy. I also understand that my insurance company is entitled, upon request, to receive information about my treatment. I understand that Family Services will bill my insurance when treatment is given. Information, which Family Services receives from insurance carriers, is sometimes inaccurate. This fact might not be known until payment is received from my insurance carrier. If this is the case, I understand that I will be responsible for charges not paid by my insurance company. I understand that it is my responsibility to inform Family Services immediately of any changes in insurance coverage.

ASSIGNMENT OF BENEFITS*:* I authorize payment of medical benefits to Family Service for services received.

*Signature of Insured or Authorized Person*_____Date_____