Joan Kaylor, MSEd, NCC

Licensed Professional Counselor, LLC

157 Waterdam Road

Suite 260

McMurray, PA 15317

Phone: 724-942-5477 Fax: 724-942-5479

CONSENT TO TREATMENT FORM

INSTRUCTIONS: Please read this form carefully before signing. If there is anything you do not understand, ask your counselor before signing.

The fee for an evaluation is $150.00. Each additional appointment is 150.00. If you have Blue Cross Blue Shield or UPMC insurance that covers outpatient counseling, you will be responsible for the copayment, coinsurance and/or any deductible you may have. It is your responsibility to know your mental health coverage. By signing this consent form you give your counselor permission to report all mandatory information to your health insurance care manager, discuss your treatment, bill your insurance for services and charge any balance due to your credit card.

Each therapy session is scheduled for sixty (60) minutes. If you need to change your appointment, please call 24 hours in advance of the appointment. If you do not show for an appointment or cancel the same day, you will be charged for one appointment. A credit card is required to guarantee appointments.

I authorize my credit card be charged for No Show, Same day cancellation, copay, coinsurance or deductible fees.

Visa Mastercard Discover American Express

Card Number Exp Code Signature

Therapy is a confidential service with the exception of a counselor's legal duty to warn or protect if suicide, homicide or child or elder abuse is suspected. Professional counselors do not have confidentiality in court. If you are in litigation, your counseling sessions are not confidential.

Due to my work schedule, I am often not immediately available by telephone. While I am in my office daily, I will not answer the phone when I am with a client. When I am unavailable, my telephone is answered by an answering service that I monitor frequently. I will make every effort to return your call on the same day, with the exception of weekends and holidays. (In emergencies go to your nearest hospital emergency room and call your primary care physician). If I am unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

This is to confirm that I have been advised of counseling services available at Joan Kaylor, MSEd, NCC, Licensed Professional Counselor, LLC and that I give my consent to receive counseling for myself and/or my dependent children

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In signing this form I indicate that I am aware of my rights, responsibilities and financial obligations as a client of Joan Kaylor, MSEd, NCC, Licensed Professional Counselor, LLC

Client(s) or Parent(s)_____Date_____

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Witness_____Date_____