

Gold Circle Counseling LLC

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CONSENT TO TREATMENT

I acknowledge that I have received, have read (or have had read to me), and understand the Gold Circle Counseling, LLC, Client Policies. I have had all my questions answered fully.

I do hereby seek and consent to take part in treatment at Gold Circle Counseling, LLC. I understand that discussing treatment goals regularly in reviewing our work toward meeting those goals are in my best interest. I agree to play an active role in this process.

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. (For example, if my appointment is at 9am, I am aware that I need to call by 9 am the day prior to my scheduled appointment.) If I do not cancel and do not attend the appointment, I may be charged a fee for that appointment.

I hereby authorize release of information by Gold Circle Counseling, LLC to my insurance company and also authorize my insurance benefits to be paid directly to Gold Circle Counseling, LLC for services rendered. I agree that I am financially responsible for all charges not covered by my insurance. Further, I grant release of all information in my file to Methodist Health Partners, (a third party organization which contracts with certain insurance companies) to provide for quality assurance in providers such as Gold Circle Counseling, LLC., for the purpose of record keeping audits. Further, I grant release of information to third parties involved in the billing and collection of fees for services rendered by Gold Circle Counseling, LLC sufficient to perform that function. I agree by signing this consent I release all information in my file to be shared with Gold Circle Counseling, LLC providers who are involved directly in my care.

My signature below shows that I understand and agree with all of these statements.

Signature of Client

Date

Signature of parent, legal guardian or power of attorney

Date

(if Client is under the age of 19)

Printed name Relationship to Client