Cypress Creek Therapy & Relationship Center

Karen Berner Arcuri, LMHC

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CONSENT FOR TREATMENT

I _____voluntarily agree to receive mental health or addiction assessment, treatment and services for myself and I understand I may stop such treatment or services at any time.

- I acknowledge that no guarantees have been made to me as to the effect of such assessment, treatment or services.
- **I understand that discussions between a therapist and a client are confidential.** No information will be released without my written or verbal consent except as stipulated by the Florida Statutes or Federal Regulations or Health Insurance Portability and Accountability Act of 1996.
- **I have read the General Privacy Practices Notice and have been offered a copy**

FINANCIAL RESPONSIBILITY/FEES FOR SERVICES

Appointments are typically scheduled on a weekly basis and are approximately **45-50 minutes** in length. More frequent sessions are available if determined appropriate. **Appointments cancelled or rescheduled less than 24 hours in advance are subject to a $35.00 cancellation fee.** Payment plans are at the sole discretion of the therapist. Payment is due at time services are rendered.

If using insurance: I authorize my medical insurance company or employee assistance company to pay directly to the therapist rendering services; Karen Berner Arcuri, LMHC. ***I understand that I am responsible for all fees, including fees for services not covered by the insurance company including deductibles and co-payments***. I may revoke this consent upon written notice. Should collection processes become necessary due to lack of payment for services we will only disclose the minimum amount of PHI necessary for collection purposes.

COMMUNICATION OF APPOINTMENTS/MESSAGES

Appointment Reminders can be sent via email, text or voicemail. Please check and/or initial all that apply:

I authorize **appointment reminders/messages** to be sent via email and/or text ☐ **yes** ☐ **no**

I authorize **text messages** to be sent to my **cell phone** ☐ **yes** ☐**no #**_____

I authorize communication via **email address(es)** provided ☐ **yes** ☐ **no:**

Email (if different than previously provided): _____

Messages will be of a non- sensitive nature

EMERGENCIES

It is not always possible to return a call immediately. However we will make every effort to respond to your emergency in a timely manner. If you have attempted to contact your therapist after hours or on weekends your therapist will contact you as soon as possible. **If you are experiencing a life-threatening emergency call 911 or have someone take you to the nearest emergency room for help**. When your therapist is out of town you will be given the number of one of the partner therapists taking call. **VOICEMAILS, TEXTS AND EMAILS CAN NOT BE RESPONDED TO IN AN EMERGENCY SITUATION.**

Client Signature: _____ Date_____

Signature of Provider _____ Date_____