TREATMENT AND AUTHORIZATION FORM

Patient Name _____

CONSENT FOR TREATMENT

I grant my permission for **myself and/or my child** to receive outpatient behavioral health services from Susan L. Charney, LCSW. I have read and agreed to the information statement provided to me.

Signed _____ Date _____

Witness _____ Date _____

FEE AGREEMENTS

Please read and **initial** the following statements regarding payment for services.

_____ I agree to cancel daytime appointments (3 pm or earlier) **24 hours in advance**, and I agree to cancel evening appointments (4 pm or later) with 48 hours notice.

_____ I understand there is a $100.00 fee for any appointments not cancelled within the 24/48 hours advance, and for appointments to which I fail to show.

_____ I agree to give my therapist **24 hours notice in advance** by voice mail for any Monday appointment for which I cancel.

_____ I understand that I am responsible for any fees not covered by my insurance plan, including cancellation fees, and I agree to pay these fees within 30 days (unless other arrangements are made with my therapist.

_____ I understand that payment is expected at the time of service. I understand that if my account is sent to collections, I will be charged the cost of collecting the balance due.

_____ I understand there will be a $25.00 charge for any checks returned for non sufficient funds.