MOONTREE PSYCHOTHERAPY CENTER, LLC

Informed Consent to Treatment & Client Rights Notice

I have been provided information regarding psychotherapy treatment and discussed the following with my provider:

1. the benefits of the proposed psychotherapy treatment;
2. the way the treatment is administered and provided;
3. alternative treatment approaches;
4. potential consequences of not receiving proper treatment.
5. any potential risks associated with the treatment;

In addition, I have been verbally informed of my rights as a client and been given access to a copy of the *Your Rights and the Grievance Procedure* fact sheet.

This informed consent is effective for up to 15 months. I understand I have the right to withdraw this informed consent at any time, in writing. I understand that I may request a copy of this notice.

Signature:	Date:
Print name:	Relationship: (parent, guardian, POA-HC)
Witness signature: (Needed only if signed with a mark)	

Notice of Privacy Practices Receipt and Acknowledgment of Notice

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Moontree Psychotherapy Center, LLC's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact the Privacy Officer by writing to: Attn: Privacy Officer, 401 Wisconsin Avenue, Madison WI 53703. I understand that I can also obtain a copy on the web at www.moontreecenter.com.

You are not required to sign this form to receive services.

Signature:	Date:
Print name:	Relationship: (parent, guardian, POA-HC)
Witness signature: (Needed only if signed with a mark)	

-OR-

❑ Client Refuses to sign but was offered a copy of Privacy Practices	
Signature of Staff Member	Date:

MOONTREE PSYCHOTHERAPY CENTER, LLC

Clinic Information and Fee Agreement

APPOINTMENTS & EMERGENCIES: All office visits are by appointment only. Voicemail is available 24 hours a day to take messages. If your call is an emergency, press "0" at the prompt and an answering service will contact your therapist. When your therapist is unavailable, another Moontree therapist will assist you.

CANCELLATIONS: **Cancellations should be made at least 24 hours in advance or you will be charged.** Your health insurance will not pay for appointments you fail to keep. You will be personally responsible to pay out of pocket.

CONFIDENTIALITY: Discussions occurring in psychotherapy are confidential or privileged communication. With few exceptions, information cannot be released without your written permission. Please read the privacy practices notice for complete information.

CLIENT'S RIGHTS & RESPONSIBILITIES: Psychotherapy has both benefits and risks. It requires an investment of your time and energy in order to make the process of therapy successful. Occasionally individuals may go through periods of rapid change, which may result in emotional discomfort, changes in their relationships, or temporary worsening of their symptoms. This should subside as therapy progresses. Remember, you always retain the right to request changes in treatment, to end treatment at any time, or to request a referral to another therapist.

HEALTH INSURANCE: It is your responsibility to know your insurance's requirements for authorization, deductibles, co-payments, and other out-of-pocket expenses. If you are using health insurance to pay for services, be aware that most insurance companies require specific clinical information about you in order to authorize and/or pay for treatment. Health insurance companies usually limit mental health coverage to:

1. Services that are considered "medically necessary". This typically means that there is evidence of a diagnosable condition with acute symptoms.
2. Conditions that are treatable by short-term, problem-focused, or goal-oriented approaches whenever possible.

This means your insurance company may only cover a limited number of sessions to address a specific diagnosis or problem. Health insurance may or may not cover all services provided. For example, insurance companies rarely reimburse for phone calls. You are ultimately responsible for the total bill.

PROFESSIONAL FEES: The standard fee for:

Initial intake	$215.00
16-37 minute session	$100.00
38-52 minute session	$140.00
53+ minute session	$195.00
Late cancel/no show	$_____
Other_____	$_____

You are responsible for paying at the time of your session unless prior arrangements have been made. You will be charged on a prorated basis for other professional services such as report writing, telephone conversations that last longer than 15 minutes, attendance at meetings, or the time required to perform any other service which you may request. If you anticipate becoming involved in a court case, you should discuss this fully with your therapist before you waive your right to confidentiality. If your case requires your therapist's participation, you will be expected to pay for the professional time required even if another party compels the testimony.

Signature:	Date:
Print name:	Relationship: (parent, guardian, POA-HC)
Witness signature: (Needed only if signed with a mark)	