MCS Counseling Group, LLC

TREATMENT CONSENT & FEE AGREEMENT - Medication Management

Treatment Consent:

I hereby give my consent for assessment and treatment with MCS Counseling Group, LLC and I understand that treatment is contingent upon my signing this consent form. I further agree to work with MCS Counseling group, LLC in evaluating my treatment needs, developing goals, and achieving those goals. I further agree to allow MCS Counseling Group, LLC to leave messages at the phone numbers I have provided, whether to a person or machine, identifying the caller as MCS Counseling Group, LLC.

I understand that I have the right to review the privacy notice, the client rights statement, and the counselor disclosure prior to signing this consent. I have been provided a copy of each of these documents and I understand that I may ask any questions that may arise. MCS Counseling Group, LLC reserves the right to change the privacy practices and the client rights retroactively, meaning that the terms of the notices may change. In the event of a change in practices, I understand that the current versions will be provided me.

I understand that protected health information may be used and disclosed to carry out treatment, payment or health care operations.

I understand that I have the right to request restrictions on how my protected health information is used or disclosed for treatment, payment or health care operations. However, MCS Counseling Group, LLC does not have to agree to my restrictions, but if he does, the restrictions will be binding.

I understand that I have the right to revoke this consent in writing, except to the extent that MCS Counseling Group, LLC has taken action in reliance on the consent.

Fee Agreement:

I agree that I am financially responsible for all services provided. I understand that billing my insurance is a courtesy. MCS will agree to bill insurance up to two times for each session. I agree to pay for sessions as per the agreement with my insurance company in regards to co-insurance/co-pays/deductibles. I agree that I am financially responsible for all services provided. I agree to pay full amount at the time of service. The fee for psychiatric evaluations is $350. Follow up sessions are $200 per session. Payment are due at time of the visit.

______ (initial) Any co-pay or deductible payments will be due at the time of visit.

______ (initial) If I am paying by personal check and it is returned as NSF I will incur a $30 return check fee.

______ (initial) I understand that repeated cancellations and/or not showing for scheduled appointments may result in a review for the need for continued services**. 24 hours notice is required for a cancellation.**

______ (initial) I understand that I will be financially responsible for appointment that I do not show up for without notice (or same day notice) at FULL SESSION RATE.

______ **(initial)** I understand that I will not carry a balance owed on my account and that if there is one that my account will be sent to collections after 90 days. I agree to pay any collection fees associated with this process.

______________________________	______________________________
Client Signature	Date
______________________________	______________________________
Parent/Guardian	Relationship