NWC COUNSELING
COUNSELING INDIVIDUALS COUPLES FAMILIES
1 Windsor Cove | Suite 303 | Columbia SC | 29223
nwccounseling.org • admin@nwccounseling.org • 803.851.6801

Consent for Psychotherapy Services

I _____ have received, read, and understand the disclosure statement, informed consent, intern consent and HIPAA notice.

- I hereby authorize payment of insurance benefits to this office for services
- I authorize the release of any medical/psychological information necessary to process claims or records keeping requirements.
- I understand that I am financially responsible to this office for all copayments and charges even if my claim is denied by my insurance carrier.
- I understand that my account can be invoiced for outstanding debt and/or charged if my card is on file.
- I understand that I financially responsible for understanding my deductible and coinsurance charges through my insurance provider.
- I understand that payment is due prior to session and should I not have payment will be invoiced and unable to schedule additional sessions until account is current.
- I understand my rights and responsibilities as a client and my therapist's responsibilities to me under HIPAA.
- I understand that I'm voluntarily seeking services and have rights in choosing, changing and terminating my sessions.
- I understand that there are no guarantees in treatment results.
- I am over the age of eighteen.

My signature below shows that I understand and agree with all of the above statements. The parties agree that this agreement can be electronically signed. The parties agree that the electronica signature appearing on this agreement are the same as handwritten signatures for the purposes of validity, enforceability, and admissibility.

Signature: _____ Date: _____

For clinician use only – My professional observations and interactions with the above referenced person gives me no reason to believe that he/she is unable to give informed consent to treatment.

Clinician's signature: _____ Date: _____