Jessica Diller, MSW, LCSW
Pathways to Growth Counseling
5200 Park Road Suite 236 Charlotte, NC 28209
704-443-8526

CLIENT CONSENT FOR TREATMENT AND BILLING AGREEMENT

I hereby give Jessica Diller, MSW, LCSW, through Pathways to Growth Counseling to provide counseling services to:

_____ _____
Client Name Date of Birth

I understand that Jessica Diller, MSW, LCSW will provide the following service(s) to me for the indicated fees:

Cost of Treatment:

Intake/Initial Session	$135	Phone Consultation (per hour)	$100
Individual Therapy	$110	Marriage/Couples/Family Therapy	$125

I understand that payment for services are expected at the conclusion of each session unless previous arrangements have been made (as indicated below) and agreed upon with Jessica Diller, MSW, LCSW. If insurance arrangements have been made prior to the session and a co-pay is applicable, it is due at the time of my session. If for any reason your insurance does not agree to pay your fee (co-pay or percentage), you are ultimately responsible for payment in full.

In order to guarantee payment a credit card must be put on file and will be billed only with notice by Jessica Diller for a missed or unpaid appointment. Please complete both sections if using HSA/FSA card.

Credit Card #_____ **Exp.**_____ 3 digit code:_____

Billing Address Zip Code_____ **VISA** **MASTERCARD**

Name as it appears on Card_____

HSA/FSA Cards (to be billed for sessions only, not eligible for missed/late cancel appts)
Credit Card #_____ **Exp.**_____ 3 digit code:_____

Billing Address Zip Code_____ **VISA** **MASTERCARD**

Name as it appears on Card_____

Your insurance company has informed me that your benefits are as follows:

Insurance Company:_____ **Deductible:**_____ **Co-pay:** _____

Max. # of sessions/Amount_____ **Per Calendar Year/Benefit Period:**_____

I agree to allow Jessica Diller, MSW, LCSW, to bill my insurance company directly for service provided and understand that the insurance company may request information in order to process payment. I give her permission to release the necessary and requested information to the insurance company.

If payment is not made at the time of my appointment and it is not a matter of special arrangement agreed upon by myself and Jessica Diller, MSW, LCSW, payment must be made within 7 working days of the session in question AND before a new appointment can be scheduled. If payment is not made within this time period, Jessica Diller, MSW, LCSW has the option of informing me, in writing, that future services might be jeopardized and even discontinued. I understand that she can provide me with names of other practitioners if requested.

If I fail to cancel a scheduled appointment at least 24 hours in advance, I understand that an ***automatic*** charge of $70 will be made for the missed appointment. I understand that I will be responsible for this fee as insurance does not pay for missed appointments. You can call me at 704-443-8526 to notify me or leave a message. If I fail to attend two consecutively scheduled sessions without notifying Jessica, she may assume that I wish to terminate services and she will notify me, in writing, that services have been terminated. I also understand that two consecutively cancelled sessions without prior notice may result in loss of an established appointment time. I also understand that I may terminate services at any time by notifying Jessica Diller, MSW, LCSW. Parents of minor children attest by their signature that they will not demand session content from Jessica Diller and will uphold the confidentiality of the child's treatment with the understanding that the counselor, by law, has to report if the child threatens harm to self or others or if he/she discloses that he/she has been harmed.

Children whose parents are involved in divorce/custody proceedings agree to allow my work with their child to remain therapeutic and not to involve me, or the treatment I do with minor clients in legal proceedings. My role is to remain as an advocate/safe person for your child and subjecting the treatment process to legal proceedings prohibits the efficacy of treatment and can potentially cause your child undue emotional harm.

Custody evaluations are done by trained professionals that are specifically involved in making recommendations related to custody. This includes standardized testing and evaluations. This is **NOT** a service I provide, nor is it the role I take as your child's therapist. I will, however, make recommendations should I have concerns through my work with your child related to parenting.

If for any reason I am requested to testify in court regarding your case my fee is $500.00/hour. This includes travel and waiting time. I require a $1000.00 retainer fee in advance. You will be responsible for payment of this fee in full. I will also no longer be able to see your child in therapy, as testifying in court breaches the client/therapist relationship.

_____
Client Name (Printed)

_____ _____
Client Signature Date

_____ _____
Therapist Signature Date