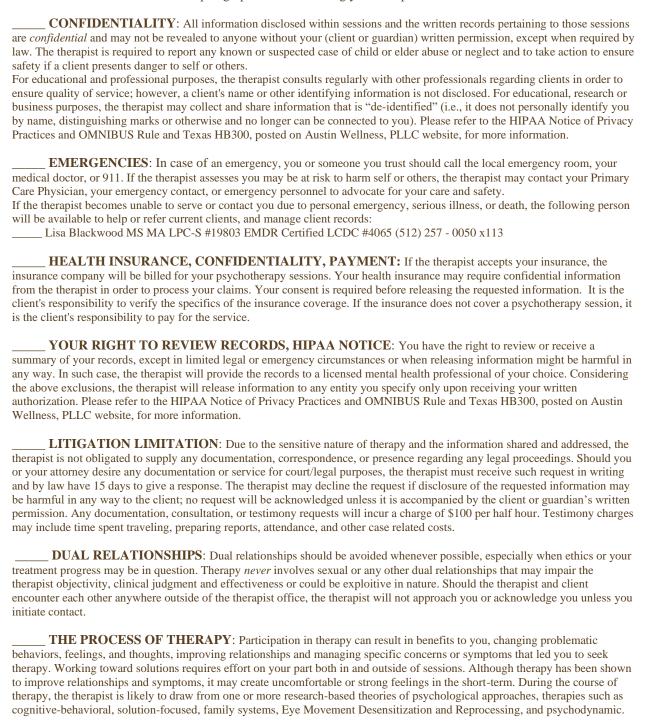


Austin Wellness, PLLC www.austin-wellness.com 10010 Anderson Mill Rd. Austin Texas 78750 512-257-0050

Consent and Policy - 1 of 2 Revised 2021

CONSENT FOR TREATMENT AND PSYCHOTHERAPY SERVICES AND POLICIES FORM

Please read and initial next to each paragraph below indicating your acceptance:





Austin Wellness, PLLC www.austin-wellness.com 10010 Anderson Mill Rd. Austin Texas 78750 512-257-0050

Consent and Policy - 2 of 2 Revised 2021

| MINORS: Parents have a right to receive progress registrated by a child during an individual session will be kept confisomeone else. Young people may not confide in a counselor if parents. If applicable, the therapist must receive a copy of the rist to ensure proper consent, confidentiality and disclosure of intreatment, and all with custody rights must consent to treatment consent may apply to minors 16 years or older who present for substance abuse, pregnancy issues, and/or are emancipated. | idential unless it involves imminent danger to they believe that personal information will be most recent divorce decree or custody order at the formation. All parent/guardian parties must be to finite minor at or prior to the first session. Except | he child or evealed to their he first session; this informed of cions to parental |
|--|---|--|
| DURATION, TERMINATION: The duration of t goals developed together, and effort toward those goals in and your active involvement, honesty, and openness. The client's go initial goals and focus developed by the 3rd or 4th session. The process gains made during treatment, and issues to be addresse met all therapy goals and attends a termination session. The the scheduled or attended for 60 days, unless a different therapy so therapist to resume therapy, and will be accommodated according. | putside of sessions. Therapy is most likely to be pals and course of treatment will be discussed put therapist requests notice before therapy is termed in the future. Therapy will be deemed "Termi trapist will consider a client "Inactive" if no session hedule has been agreed upon. Inactive clients in | e successful with periodically, with hinated in order to nated" if client has sion has been hay contact the |
| PAYMENTS, FEES: Payment in the amount of your fee is due at each session. The therapist accepts cash, check, or credit card. The fees are \$300 for the initial Diagnostic Assessment one-hour session. Subsequent session fees are \$200 per 50–60-minute session, \$100 per 30-minute session. Session times include approximately 5-10 minutes for the therapist to complete documentation of the session. Telephone conversations, report writing/reading, release of information, longer sessions, etc. will be charged at the same rate, unless indicated and agreed otherwise. Please notify the therapist if any problem arises during the course of therapy regarding your ability to make timely payments. A fee of \$50 will be assessed for returned checks. Intern Fees: \$175 Initial Diagnostic Assessment, Subsequent sessions \$125 per 50-minute session. | | |
| PHONE CALLS, EMAIL: If you need to contact to charge. The therapist has a confidential voice mail for messagin (excluding holidays/vacations). Messages received late in the domake, cancel, or reschedule an appointment, or make brief repeaddressed by email. Text messaging to communicate with the your preferred email address and phone contact: Email: | ng. Phone messages and emails are checked Mo ay may be returned on the next business day. P orts about your progress. Therapy issues or crise therapist, is not a secure way to transmit inform | onday - Friday lease email to es will not be nation. Please list |
| CANCELLATION: The full fee is charged for "no scheduled time. An appointment is considered cancelled when not pay for missed or cancelled appointments. Payment is due a session. Credit card information is kept on file with your medi appointments and balances due on your account. Circle type of card Visa / MC / AMEX - CC#: V Code on the back OR AMEX 4 numbers on the front: Signature for payment approval: | not attended at the agreed time and date. Insura for any missed appointment before or at the beg cal records and charges will be billed for any ne Exp. Date:Billing address and Zip Code: | nce companies do ginning of the next to show |
| CLIENT/GUARDIAN: I have carefully read, understand, and agree to comply with the above policies and information, and consent for treatment and psychotherapy services. | | |
| Client Name (Print): | Signature: | Date: |
| Parent/Guardian Name (Print):Parent/Guardian Name (Print): | Signature: Signature: | Date: Date: |
| I have discussed the above issues and policies with the client/parent(s). My observations of this person's behavior and responses give me no reason to believe that he/she is not fully competent to give informed and willing consent to treatment. | | |
| Signature of Therapist: | _ | Date: |