North Oakland
Family Counseling Center P.C.
6887 Dixie Highway – – Clarkston, MI 48346
(248) 620 -1019 – Fax: (248) 620-1026

Consent for Treatment and Recipient Rights Client Confidentiality
Verification of Receipt and Understanding

1. In accordance with my income and current financial circumstances, I have authorized N.O.F.C.C / N.O.C.A to bill me or my insurance company in the amount of $120.00 per 45 minute session, $200.00 per 53+ minute sessions $200.00 per intake and $135.00 per family session for sessions rendered. I understand any information contained in my record may be released to my insurance company upon request. If however, I am experiencing a financial hardship I may qualify for a reduced rate based on my income. If I have insurance I understand my benefits may not cover the full fee for service and I am responsible for the following:

   Deductible_____ **Co-pay**_____

   Negotiated Cash Fee: Intake _____ Individual Therapy _____

   (Negotiated fee only applies if you do NOT have insurance coverage)

2. I agree to bring to this office any and all vouchers and forms from my insurance company, that I receive regarding my care in this office. I will bring the voucher and check to this office within one week of receiving it, and sign the check over to North Oakland Family Counseling Center. I understand that the checks may be in the name of North Oakland Family Counseling, my therapist, the supervising clinician's name or even my own name, and these checks still need to be returned to N.O.F.C.C / N.O.C.A.

3. I have received a copy of North Oakland Family Counseling Associates Consent for Treatment and Recipient Rights and have discussed them with the intake worker during the admissions process. I also understand my right to confidentiality as described in the handout by the intake worker.

My primary therapist will be _____

4. Failure to abide by this agreement will result in **COLLECTION IN FULL** for each visit in a court of law, and/or a collection agency. This means that the client will be responsible for the fee of $200.00 for intake, $200.00 per 53+ minute session, $120.00 per 45 minute session, and $135.00 per family session, **not** the Negotiated Fee.

5. I understand I have the right to participate in setting my treatment goals. I understand I may see a psychological intern and have the right to speak with the supervising clinician. I understand that my sessions might be recorded for supervisory purposes and have the right to decline recording at any point during treatment. I understand I have the right to terminate treatment at any time.

6. I understand that if I fail to cancel within 24 hours of my schedules appointment time or do not show up for a scheduled appointment, I will be responsible for the _____ charge per session.

7. The patient understands that this written agreement is the entire agreement between the parties. Any modifications to this agreement, including any changes in the fee, must be in writing, signed and dated by both the patient and the therapist.

_____ _____
Patient/Parent/Guardian Signature Date

_____
Patient Name

Therapist Initials _____