



# LIVING WELL COUNSELING CENTER

## CONSENT TO TREAT

THE FOLLOWING INFORMATION IS INTENDED TO PROVIDE INFORMATION ABOUT PSYCHOTHERAPY SERVICES WITH PRISCILLA THOMPSON, LCMHC AND VALERIE JONES, LCMHC. WE WOULD BE HAPPY TO ANSWER ANY QUESTIONS OR PROVIDE FURTHER INFORMATION.

- **Cash or check is preferred for copays.**
- If you need to **cancel your appointment**, please do so at least 24 hours in advance to allow for another person to schedule an appointment during that time. If less than 24 hours advance notice is given, a **cancellation fee of \$50** will be charged.
- Each therapy session is scheduled for **45-55 minutes**.
- Please bring your **insurance card** to your first appointment for photocopying or email a scanned copy.
- Please **print out and read** the accompanying “Office Policies, Procedures, and Information” and “Practices Regarding Your Protected Health Information” documents, as well as “Informed Consent for Telemental Health Services.” The documents are provided on the website, [www.livingwellnh.com](http://www.livingwellnh.com), under Client Paperwork.

By signing this form you are indicating that you have read and agree to the above information. **You are also acknowledging that you have read and comprehended the following documents: “Practices Regarding your Protected Health Information (PHI),” Office Policies, Procedures and Information,” as well as “Informed Consent for Telemental Health Practice.”**

\_\_\_\_\_  
Signature of Client

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Printed Name of Client

\_\_\_\_\_  
Printed Name of Witness

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date