2109 Hamilton Road Suite 100, Okemos MI 48864
517-375-2672

Welcome to my practice. I am pleased to have the opportunity to work with you. This document contains important information about my professional services and procedures. Please read it carefully and discuss any questions you have with me. Please initial in the space immediately preceding each clause to indicate you have reviewed the section. When you sign this document, it will represent your informed consent for therapy services.

______ **Consent to Treatment:** I understand that the services I and/or my dependent(s) will receive are based on currently accepted practices in the field of mental health. Psychotherapy has both benefits and risks: while it is empirically demonstrated to have beneficial effects on emotions, behaviors, and relationships, at times it can also arouse distressing thoughts, feelings and behaviors. There are no guarantees as to the results of treatment or of any procedures. It is important to let me know of any concerns you have about your response to our sessions.

_______ **Professional Fees and Insurance Coverage:** Your health insurance may cover my services (with conditions regarding number of sessions, fee limits, co-pays and deductibles). If I am a participating provider for your plan I will accept their assigned fees and I will bill them electronically. Your co-pay will be due at each session by cash (preferred), check or credit. If for any reason your insurance does not cover your sessions you will be responsible for up to the full billed amount. Payment in full is expected at each session unless otherwise arranged. *The returned check fee is $30. A monthly rebilling fee of 10% will be added to outstanding unpaid balances. Accounts past due 90 days will be sent to collections.*

_______ **Cancellations/Missed Appointments:** I understand that the full session fee is charged for appointments missed and for appointments cancelled less than 24 hours in advance. Insurance will not cover missed appointments. *Cancellations cannot be made via text message*.

_______ **Availability:** I routinely check my voicemail and will do my best to return your call within 24 hours. Phone calls lasting more than 10 minutes will be billed at the agreed-upon hourly rate . In case of emergency, contact UM Psychiatric Emergency Services at 734-996-4747, go to the nearest hospital emergency room or call 911.

Informed Consents:

My signature below shows that I understand the information provided in this document and that I consent to treatment. It also serves as acknowledgement that you have received a copy of the HIPAA Notice.

____

Printed Name

____ ______________________________

Signature Date

Payment agreement:

I authorize the release of any protected health information necessary to process insurance claims for payment. I hereby authorize payment of insurance benefits to be made directly to Candice Carrasco, PLLC. I understand that I am financially responsible to Candice Carrasco, LMSW for services not covered or payable by my insurance carrier.

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Signature Date