Separated/Divorced Family Consent Form

CLIENT'S NAME: ____**DOB:** ______________________________

NAME OF PARENT: ____**DOB:** _____________________________

NAME OF STEP-PARENT: (if any) ____**DOB:** _____________________________

ADDRESS: ____

HOME PHONE: _______________________ **CELL PHONE**: _______________________

If you have any questions about psychotherapy or our office policies, please ask before signing below. Your signature indicates that you have read our office policies and that you seek and agree to enter into mental health services under those conditions. You understand that no promises have been made to you as to the results of any treatment or procedure provided by this provider. Further, it indicates your understanding that Lisa Porisch Counseling may terminate services if there is a lack of compliance with these policies or if we believe that you are not benefiting from treatment.

CONSENTS

1. **Consent for Evaluation and Treatment:** Consent is given for assessment and treatment by Lisa Porisch Counseling.. I understand that at times cases are staffed anonymously between the professional staff; I consent to this procedure. It is agreed that either the provider or I may discontinue evaluation, consultation, and/or treatment at any time and that the client is free to accept or reject the services offered or provided.

3. **Assignment of Insurance Benefits / Payment Agreement:** Lisa Porisch Counseling will file all insurance claims unless otherwise directed. In the event that a client or responsible party is entitled to insurance benefits of any type arising from any policy which insures the client or other liable person, those benefits are hereby assigned to the provider for credit toward bills. The client and/or responsible party shall be financially responsible for any charges not paid by insurance. If payment is not made directly to the provider, payment in full is due from the client or responsible party. The undersigned agrees to pay the provider the assessed charges, in full, at the time of service unless other arrangements have been authorized. Please note there will be a $50 fee on all NSF checks. Lisa Porisch Counseling reserves the right to charge interest or late fees on statements and accounts that are past due and not paid in a timely manner. It is the client's/responsible party's responsibility to set up a payment plan if he/she cannot pay their statement or account in full.

Note: *Lisa Porisch Counseling will not bill the other parent unless that parent makes arrangements with us. It is your responsibility to seek any reimbursement from that parent. If your child is a client, you are requested to inform the other parent that your child is receiving services at Lisa Porisch Counseling.*

4. **Release of Information for Medical Insurance Coverage to Insurance, Managed Care or EAP Company:** In order to process and determine benefits payable, I hereby authorize my provider to release any necessary part of the client's record, as specified by the Notice of Privacy Practices, to any insurance carrier or entitlement program, which may be obligated to pay all or part of treatment charges. A photocopy of this authorization shall be considered as effective and valid as the original. This authorization shall remain in effect and valid until this office receives a written revocation signed by the client or other authorized person. I certify that the information I have furnished is true and correct. Lisa Porisch Counseling bills through a private billing specialist. Check with office personnel for doctor specific contact numbers. Personal checks that identify you will be presented for deposit at your provider's financial institution.

5. **Consent for the use of Email and Texts:** Lisa Porisch Counseling cannot guarantee, but will use reasonable means to maintain, security and confidentiality of email and text information sent and received. Lisa Porisch Counseling is not liable for improper disclosure of confidential information that is not caused by intentional misconduct. By signing below the client and/or responsible party is acknowledging and consenting to receive non-encrypted email and text message communication.

6. **Credit card services will be processed by Ivy Pay.**

7. **I consent for telehealth services.**

____ _______________________

SIGNATURE **DATE**

Mental Health Therapy and Court Custody Issues

One of the main tenets of counseling/mental health therapy is to "do no harm." This concept is extremely relevant in seeing children who are involved in family court custody issues. The therapy relationship is built on trust, and the basis of this trust is of utmost importance.

A parental agreement is needed stating that if a child is undergoing therapy, there will never be a time that the parent will try to subpoena records. Records will not be subpoenaed regarding any child custody issue because child custody is adversarial by nature.

The therapist will not communicate the process or content of the therapy to anyone except the parenting coordinator, who is a neutral party, and who has only the best interest of the child in mind.

I hereby agree that I will not subpoena my child's records at this time or any date in the future.

______________________	______________________	___________
Parent's Printed Name	Parent's Signature	Date
______________________	______________________	___________
Parent's Printed Name	Parent's Signature	Date