Carolina COUNSELING CONSULTANTS
PURPOSE DRIVEN COUNSELING SERVICES

WWW.CAROLINACOUNSELINGCONSULTANTS.COM

CONSENT TO TREATMENT

I voluntarily consent to receive counseling services from Christalyn Howard, LPC for myself (or my child if said child is the client). I understand that Christalyn Howard, LPC is acting as an Independent Practitioner. I have read and understand the Professional Disclosure Statement for Christalyn Howard, LPC, and the Client's HIPAA Rights form. I understand that I may stop services at any time. I understand that I can end the therapy session at any time, or disregard any suggestions made by Christalyn Howard, LPC during a scheduled session. I understand that if I am consenting to treatment of a minor child, and a court order has been entered with respect to the guardianship of said child, Carolina Counseling Consultants, LLC will not render services to the child until the therapist has received and reviewed a copy of the most recent applicable court order.

Please initial:

_____ I consent to treatment and I understand my rights as a client including the limits to confidentiality.

FEE AGREEMENT: CASH OR CREDIT CARDS ACCEPTED (All payments are due at each session)

_____ I understand the following are standard fees for services:

-Diagnostic Assessment: **$150** (Generally lasts 1 hour 30 minutes)
-Individual Session: **$100** per hour
-Family and Couples Session: **$125** per hour
-$25 each additional half hour
-Court Work (documentation preparation, court appearances, or consultations): **$100** per hour

_____ When applicable, I understand Christalyn Howard, LPC will bill my primary insurance **(Tricare or SC Medicaid)**. I understand that I am responsible for any unpaid fees, deductibles, copays, or unpaid insurance claims. I understand that all copays are due at each session.

_____ I understand I must cancel or change my appointment 24 hours in advance to avoid a **$25** missed appointment charge or late cancellation fee. The fee will automatically be charged to the card on file or it must be paid before the next scheduled session if I typically pay with cash. Leaving a message or sending a text to 803-470-3876 is sufficient for cancellations.

_____ _____

Client's Printed Name **Parent/Guardian/Legal Representative's Printed Name**

_____ _____

Signature of Client OR Parent/Guardian or Legal Representative **DATE**

_____

Therapist Printed Name

_____ _____

Signature of Therapist **DATE**