Carolina
COUNSELING
CONSULTANTS
PURPOSE DRIVEN COUNSELING SERVICES

WWW.CAROLINACOUNSELINGCONSULTANTS.COM

CONSENT TO TREATMENT

I voluntarily consent to receive counseling services from Dina Armstrong-King, LPC for myself (or my child if said child is the client). I understand that Dina Armstrong-King, LPC is acting as an Independent Practitioner. I have read and understand the Professional Disclosure Statement 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 my counselor 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 any services to the child until the counselor/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 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 Dina Armstrong-King, LPC will bill my primary insurance **(Tricare, Blue Cross Blue Shield, 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**