# Acknowledgment Form

May we contact the person or organization who referred you? Circle Yes No
If Yes, Please list name and phone number: _____
_____

**GENERAL CONSENT TO COUNSELING**

I consent to begin counseling, including evaluation, treatment or referral. I agree to pay for counseling services including medical, psychological or psychiatric consultation fees and testing charges. All clients will be charged the therapist's standard fee for cancellations made with less than 24 hour notice or for failure to show for an appointment. Note: This charge is not covered by insurance. Unforeseen emergency situations will be taken into account.

I have read the *Informed Consent for Counseling /fee policy* and I understand and agree to the policy described herein. I have also read the *Disclosure Statement* which documents my counselor's degree(s), credentials and license(s). A copy of these documents have been given to me for my records.

**I agree to pay as services are rendered in the following manner:**

- ❑ I will pay the contracted fee at each visit
- ❑ I will pay the co-payment as required by my insurance company, managed care agency or HMO
- ❑ Payment will be covered by an outside agency

I acknowledge that I have given my correct and complete insurance information below. I understand that if I have given incomplete or incorrect information that I will be responsible to pay for services.

## Please fill out both primary and secondary insurance information below:

***Please write neatly***

**Primary Insurance Information:**

Name of Insurance:_____
Name of Policy holder:_____
Primary Insurance ID#: _____
Insurance Group #: _____
Policy Holder SSN: _____-_____-_____
Policy holder Birth date: _____
Name of Insured Person:_____
Insured's birth date: _____
Relationship to Policy holder: Self/ Spouse/ Parent /Other

**Secondary Insurance Information**

Name of Insurance Co.:_____
Name of Policy Holder:_____
Secondary Insurance ID#: _____
Insurance Group #: _____
Policy Holder SSN: _____-_____-_____
Policy holder Birth date: _____
Name of Insured Person: _____
Insured's birth date: _____
Relationship to Policy Holder: Self/Spouse/Parent/Other

Print Name of Client: _____ Date: _____

Print name of Parent/Guardian *if client is a minor*: _____