Trish Murray, PhD, LPCS, NCC, ACS

Consent for Treatment

- I acknowledge that I have received, have read and understand the "Client Information" sheet and/or other information about the therapy I am considering.
- I do hereby seek and consent to take part in counseling with Trish Murray, PhD, LPCS, NCC.
- I understand that no promises have been made to me as to the results of treatment provided by this therapist.
- I am aware that I may stop treatment with this therapist at any time. The only thing for which I will be held responsible is paying for the services I have already received.
- I understand that I will be charged based on the amount of time with my counselor. I understand that any additional time (consultations with attorneys, psychological reports, letters, etc.) will be prorated at the hourly rate. I am responsible for payment when services are rendered. I understand the fees for sessions with Trish Murray, PhD, LPCS, NCC are:
  - Initial Session - $_____.00 (50 min);
  - Subsequent Sessions - $_____.00 (50 min);
  - Court Time is assessed at $250.00 per hour for preparation, travel time and testimony.
- I know that I must provide at least **24 hours notice** to my therapist if I am unable to keep my scheduled appointment time. I understand that I will be assessed a fee if I fail to inform my counselor.
- If I am using insurance, I am aware that an agent of my insurance agency or other third-party payer may be given information about the type, cost, date and providers of any services or treatments I receive. I also understand that by using insurance to process a claim, the therapist must render a diagnosis. **I authorize the release of any medical or other information necessary to process a claim.**
- I understand that if payment for the services I receive here is not made, the therapist may stop my treatment.
- I understand that whatever I say will be kept in confidence with the exception of the conditions mentioned in the "Client Information" sheet.
- I understand that *CrossBridge Counseling* cannot guarantee the absolute confidentiality of fax, cell phone, and/or email communications because of technological limitations.

My signature below shows that I understand and agree with all of these statements.

_____	_____
Signature of Client	Date
_____	_____
Signature of Spouse / Significant Other (if Necessary)	Date
_____	_____
Signature of Therapist	Date