Client Name: _____ Client #:_____ Adm. Date: _____

Community Counseling of Central Connecticut Inc.
53 Muir Ave Bristol, CT. 06010
860-582-7904 cccofcentralct.org
We treat people not privilege…

CONSENT TO TREATMENT

I,_____, give my permission and consent to **CCC of Central CT Inc.,** to provide psychotherapeutic treatment to me and the following family members (if applicable)_____
_____

I understand that there can be benefits to our working together such as improved communication, interpersonal relationships, or methods of coping. While I expect benefits from this treatment, I fully understand that because of factors beyond our control or other factors, such benefits and particular outcomes cannot be guaranteed. I may experience emotional strains, feel worse during treatment, and make life changes that may be distressing.

I understand that this therapist is not providing an emergency service though CCC does provide 24 hour phone coverage. I may leave a voice mail message at **860-582-7904**, however if this is an emergency and I am unable to wait for a return call I will call **911**.

I understand that conversations with the therapist and my records are confidential except in the following situations:

1. I am in serious danger of harming myself or at serious risk for harming another person (when under 18, chronic or increased substance abuse or acting out behavior may constitute form of danger to self or other and parents may be informed).
2. I am abusing or neglecting a child, an elderly person, or a disabled person in my care or I am the recipient of that abuse or neglect.
3. A court order compelling my therapist to release records.
4. In certain supervisory or peer review situations and then my identity is concealed whenever possible.

I will attend all agreed upon sessions and if unable to keep an appointment will notify the therapist at least 24 hours in advance. **Failure to give 24 hours notice will result in a "no show" administrative fee of $50.00.** Continual issues with not showing up at the time of appointment can result in discharge.

I understand that insurance will not reimburse me for missed sessions, nor will they pay for the following services: Phone calls/phone sessions, letters/reports, disability paperwork or consultations. **Services that are requested but not covered by insurance will be billed directly to me at a rate of $135.00 per hour**. These include but are not limited to: Phone based work that

lasts over 10 minutes, letters/reports (non routine), disability paperwork or consultations. Travel time to and from meetings will be billed at the standard rate.

I understand that court related services are not covered by insurance companies and that should ℂℂℂ or any of its representatives be required to appear in court or court related meetings (depositions, planning, preparation etc.) that the daily fee for court related services is **$3000.00 per day, per representative and will be paid in advance**. I further understand that this **fee is non negotiable** and that services are not offered on a per hour basis other than **report writing, which is offered at $300.00 per hour**. I further agree to give ample notice of any need for court related services. ℂℂℂ reserves the right to refuse court related activities.

I understand that ℂℂℂ will at times offer to loan materials to me to be used as part of therapy (most notably books for Bibliotherapy), I agree to return all items in the condition given to me and to do so in a timely manner or to pay current retail replacement price.

While ℂℂℂ will submit bills to my insurance carrier, I understand that I am financially responsible for all sessions and payment is due at the time service is rendered. Co pays, deductibles and related fees will be paid prior to going into my therapeutic session. Fees for a 45 minute session are $135.00; group sessions are $70 per person and all fees are subject to change with or without prior notice. I further understand that ℂℂℂ reserves the right to refer delinquent accounts to collection agencies for the purpose of collecting outstanding fees for services.

I am free to discontinue treatment at any time; however, I realize that when I have reached my goals it is important for me to discuss this in session and plan for termination with my therapist. If I do plan to discontinue treatment I will advise my therapist.

I know of no reason I should not undertake this therapy. I have read this policy, have been given a copy of it and I agree to participate fully and voluntary and in agreement with the above conditions.

_____ _____
Client Date

_____ _____
Parent/Guardian or legal representative (as applicable) Date

_____ _____
CCC representative Date