Michelle Allison LMFT● 638 Browns Road ● Mansfield, CT 06250 ● 860 933-5072

CLIENT CONSENT TO TREATMENT

_____I consent to treatment by Michelle Allison LMFT for myself.

_____I consent to treatment by Michelle Allison LMFT for:

_____DOB _____

for whom I am a legal representative

_____I consent to allow the disclosure of health information necessary for reimbursement to my insurance or managed care company, Medicare, Medicaid or other third party payor. This information will include a diagnosis and may also include specific information about my condition and the treatment process.

This consent will remain in effect for the duration of treatment with Michelle Allison LMFT, or until such time as I choose to revoke it.

CLIENT FEE AGREEMENT

All co-pays, co insurance payments or negotiated fees are due and payable at time of service, unless other arrangements are made.

Clients are obligated to keep their scheduled appointments. Cancellations require 48 hours notice. Cancellations without 48 hours notice and no shows will be charged the full fee as negotiated or determined by insurance.

Last minute emergencies will be considered on a case by case basis, provided the client provides direct telephonic communication prior to the appointment.

Co-pay, co insurance or fee:_____

_____

Signature of client or legal representative Date

_____

Witness