Suzanne Roberts, LCSW
750 Old Main St., Suite 306· Rocky Hill, CT 06067 · (860) 342-0493 phone / fax

Client Consent and Agreement

- I / we have read and have been given a copy of the Routine Services and Emergencies sheet.
- I / we have read and been given a copy of the Consent to Treatment sheet. I / we give Suzanne Roberts, LCSW permission and consent to provide me / us with psychotherapy.
- I hereby attest that I am the legal parent / guardian of _____ and I give permission for Suzanne Roberts, LCSW to provide psychotherapy *(for children under the age of 18 only).*
- I / we have read and been given a copy of the About Fees sheet and understand that I / we are financially responsible for this treatment and for any portion of the contracted fees not reimbursed or covered by my health insurance, including deductibles, co-insurance, and co-payments. I / we also understand that I / we will be billed $50 for any appointments that are canceled or missed without 24 hours prior notice, and that the below insurance company will not be billed for this.
- I / we authorize the release of any medical or any other information necessary to process claims based on my / our treatment with Suzanne Roberts, LCSW. I / we also authorize payment of medical benefits to Suzanne Roberts, LCSW.

Insurance Information:

_____ _____
Subscriber's name Date of Birth

_____ _____ _____ _____
Insurance company Policy number Group number Phone number

_____ _____
Other / secondary insurance: company, policy and group numbers Phone number

_____ _____
Client / Guardian signature Date

_____ _____
Client / Guardian signature Date

_____ _____
Subscriber signature (if different from client / guardian) Date

_____ _____
Suzanne Roberts, LCSW Date