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

Consent to Treatment

This form is to document that I / we give my permission and consent to Suzanne Roberts, LCSW to provide psychotherapeutic treatment to me and/or my spouse and child/children.

While I / we expect benefits from this treatment, I / we fully understand that because of factors beyond our control or other factors, such benefits and particular outcomes cannot be guaranteed.

I /we understand that because of the counseling or therapy, I / we may experience emotional strains, feel worse during treatment, and make life changes that may be distressing.

I / we understand that this therapist is not providing an emergency service, and I / we have been informed of who to call in an emergency (see Routine Services and Emergencies).

I / we understand that regular attendance will produce the maximum benefits but that I / we are free to discontinue treatment at any time. If I /we decide to do so, I / we will notify Suzanne Roberts, LCSW at least two weeks in advance so that effective planning for continued care can be implemented.

I / we understand that conversations with the therapist will almost always be confidential. I / we further understand that the therapist, by law, must report actual or suspected child or elder abuse to the appropriate authorities. In addition, the therapist has a legal responsibility to protect anyone I / we may threaten with violence, harmful or dangerous actions (including those to myself), and may break confidentiality of our communication if such a situation arises. I / we understand that the therapist will make reasonable efforts to resolve these situations before breaking confidentiality.

I / we also understand that if I / we are utilizing insurance benefits under a managed care plan, the treatment may be subject to review by the managed care company and that said company may place limits on the scope of treatment based on its company policies and on clinical decisions of its own reviewers. Written and/or oral reports may have to be supplied by the therapist to the managed care organization.

I / we know of no reasons I / we should not undertake this therapy and I / we agree to participate fully and voluntarily.

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About Fees (effective 02/22/10)

Fees are an important issue to anyone receiving professional services. This sheet was prepared to clarify fee policies. **Please note that, if you choose to use insurance, your insurance company is often entitled to detailed information from your files as a contingency to payment.** If you prefer to not involve you insurance company, you may self-pay. The fee schedule is listed below.

Payment Method: Payment is required at the time services are rendered. Payment may be made by cash, check, or money order. Post-dated checks cannot be accepted. Returned checks incur a $35.00 fee. Should an account remain unpaid, due to unforeseen circumstances, after thirty (30) days a 1 ½% (18% per annum) rebilling and interest charge shall be added beginning the 31st day until the charges are paid in full. Once reasonable efforts have been made to collect unpaid fees, your bill may be forwarded to a collection agency. Office visits will not be rescheduled until new payment arrangements are made.

Fee Schedule:

Intake assessment session	$150
Individual session (45 – 50 minutes)	$55
Couple or family session (45 – 50 minutes)	$130
Half session (20 – 30 minutes)	$35
Individual session (70 – 80 minutes)	$175 (may not be reimbursed by insurance)
Group session (group of 3 – 7)	$55 (may not be reimbursed by insurance)
Hypnotherapy (45 minutes)	$100 (may not be reimbursed by insurance)
Telephone consultation (15 minutes)	$30 (not reimbursed by insurance)
Production of reports / records review (per hour)	$100 (not reimbursed by insurance)
Court appearances (per hour)	$200 (not reimbursed by insurance)
Case consultation / collaboration (per hour)	$200 (not reimbursed by insurance)

Missed Appointments: If you are unable to keep an appointment, please notify the office immediately. If an appointment is canceled or missed without 24 hours prior notice, you will be billed $50 for the session. Please note that your insurance company will not be billed for missed appointments. In the event of an unexpected or emergency situation, please discuss the matter with your therapist if you believe that your absence could not be avoided.

Insurance and Third Party Payments: You are responsible for knowing your insurance coverage (including the need for pre-authorization, pre-certification, co-pay / co-insurance amounts, deductibles, and referral procedures. If your insurance is accepted by this provider, any co-payment / co-insurance or deductible charges are due when services are rendered. If you change insurance companies or coverage during your time in treatment, you must notify Suzanne Roberts, LCSW immediately. If your insurance is not accepted by this provider, a bill will be given to you, upon request, to send to your insurance company for reimbursement.

Responsibility: The client (or parent/guardian) is considered responsible for professional fees. If we reach a written agreement to bill a third party and that third party fails to make timely payments, you will be notified in writing that you are responsible for payment. Payment for the full balance will be due within 30 days of that billing date.