Consent to Treatment

I hereby consent to engage in a counseling relationship and treatment with Nate Havlick, LCSW. I understand that developing a treatment plan with specific goals and regularly reviewing our work toward meeting those goals is in my best interest. I agree to play an active role in this process. I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.

I am aware that I may stop my treatment with this therapist at any time, in which case my only responsibility will be to pay for those services already received.

I understand that all appoinment cancellations must be made at least 24 hours in advance - otherwise, I will be charged $50 for the appointment. This does not apply in the event of physical emergency (illness, flat tire, etc).

I am aware that my insurance company or other 3rd-party payer may be given information about the type, cost, and dates of services received - and that if they do not reimburse for these services, the therapist may stop my treatment.

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

_____ _____
Client Name Legal representative?

_____ _____
Client Signature (or representative) Date

I, the therapist, have discussed the issues above with this client and/or a legal representative. I have observed no evidence to suggest that this person is not fully competent to give informed and willing consent.

_____ _____
Therapist Signature Date

Notice of Privacy Practices
Receipt and Acknowledgment

I hereby acknowledge that I have been given an opportunity to read a copy of Nate Havlick, LCSW's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Mr. Havlick.

_____ _____
Client Signature (or representative) Date

_____ _____
Therapist Signature Date

Financial Agreement

To be filled out with therapist at initial meeting

Health Insurance/EAP:

Client or Representative's signature: I consent and authorize Nate Havlick, LCSW to release medical or other supporting information necessary to process my insurance claims. I agree to be responsible for all deductibles and co-pays, as well as the $50 late fee mentioned above.

_____ _____ _____
Subscriber's Name Signature Date

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or *Negotiated Fee*:

I accept responsibility for paying the following fees: _____ for the initial session, and _____ for each session thereafter. I also accept the $50 late fee as described above.

_____ _____ _____
Client Initials Signature Date

This is a confidential, privileged patient medical record. Redisclosure or transfer is expressly prohibited, except where provided by law.