COUNSELING SERVICES CONSENT TO THERAPY

Deborah Wieland, M.S. LMFT #96864

Client Name:_____ Client Name:_____

Reason for seeking therapy: _____

I/We consent to counseling, psychotherapy and diagnostic testing as prescribed by the therapist. I/We agree to be responsible for all copay/coins or cash pay of $_____ per session (50 min /w notes), which is due and payable at the time of the session.

Missed session/No show fee $ 50.00 Initial _____

I understand that **any appointment not kept or cancelled with less than 24 hours** notice will be payable by me (***Monday appointments call by 5pm on Friday***). Initial _____

I consent to communication with the referring professional should the therapist consider it to be in my best interest. I consent to insurance information to third party billing associates. Use of insurance is not a guarantee of payment and if insurance denies payment or is cancelled anytime during treatment, ***I will be responsible to pay the regular fee $165.00***. Initial _____

I consent to receive or send text messages to my cell phone for scheduling or other communication. I consent to EMDR therapy when needed as directed by the therapist.

I understand that the therapist is mandated reporter in California and is obligated to report to authorities or take other protective measures should it become apparent there is danger to the client or others, or if there is reason to suspect child, spousal, dependent or elder abuse.

Signature of Client:_____ Date:_____

Signature of Client:_____ Date:_____

If Client is a minor, Signature of Parent/s or Guardian:

2nd Parent:_____

Location: 17111 Beach Blvd #203 Huntington Beach 92647
Email: talkthatheals@gmail.com Appointments call: 714-408-3702