Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:

Informed Consent **Initials**

I have read and understand the risks & benefits related to treatment and evaluation. I consent to receive mental health services by Emily Lutringer. Any questions I have regarding these have been answered.



Rights & Responsibilities

I have reviewed and understand my rights and responsibilities for receiving services at Western. This includes complaints, fees, no-show/cancellation policies, and my rights. I have a copy of these rights and responsibilities. Any questions on these have been answered.



Notice of Privacy Practices

I have reviewed Emily Lutringer's privacy practices. This includes privacy and exceptions to confidentiality. Any questions I have regarding these practices have been answered. I have a copy of these policies. I understand that Emily will share basic information with primary care provider unless I ask to "restrict" this disclosure.



Financial

If I cancel within 24 hours or do not show for an appointment, I will pay $90, or the full cost of the session. I am the "financial guarantor", meaning I will be responsible for payment of co-pays, co-insurance, deductibles, and fees for services not covered by a plan or EAP.



Advance Directive

Would you like more information about how to make a medical advance directive? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Would you like more information about how to make a mental health advance directive? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



Signature of Client or Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_

If Parent/Guardian, print name::