TWIN CITIES
MENTAL HEALTH
& COUPLES CENTER

NFORMED CONSENT AND AGREEMENT SIGNATURE PAGE

Account Responsibility: I am responsible for payment to Twin Cities Mental Health & Couples Center, LLC for all services rendered due at the time of the visit. I also understand that if I suspend or terminate my care, any outstanding balance will be immediately due and payable. If I default on any payment obligations, TCMHCC reserves the right to forward my information to collections and I will be responsible for any fee to cover the cost of this action.

Insurance Billing: I authorize Twin Cities Mental Health & Couples Center, LLC to release any medical information to my insurance company that may be deemed necessary in order to process an insurance claim. I authorize my insurance company to assign benefits to Twin Cities Mental Health & Couples Center. I understand that I am responsible for payment regardless of reimbursement of these services by the insurance company. I agree to notify Twin Cities Mental Health & Couples Center whenever I have changes in my health plan coverage or contact information. **Couple's therapy is usually not a coverable service; therefore unless we get an authorization from your insurance provider, we cannot bill your insurance for this service**.

Late Cancellation/No Show: If I **fail to cancel or do not show up** for a scheduled appointment without providing a 24 hour notice, TCMHCC has the right to charge me at the rate of $100.00 for each missed session. I understand that my health plan will not provide payment for missed appointments and it is therefore not eligible for submission to my health plan.

***Litigation Limitation*:** Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to matters that may be confidential in nature, it is agreed that the information discussed is for therapeutic purposes and is not intended for use in any legal proceedings. You, the client, or your attorney will not subpoena your therapist to testify or provide records in a court action.

Confidentiality and Release of Confidential Information: I understand that the sessions will be completely confidential and information cannot be shared unless there is a written release signed by all parties involved. However, couples therapy may include working individually as well as together with both couples present. Therefore I authorize the release of confidential information gleaned from individual sessions to be shared as part of the overall treatment, to the extent your therapist deems therapeutically necessary to meet therapy goals.

My signature below indicates my consent for treatment, and confirms that I have read, understand and consent to all the terms and conditions of the Informed Consent and Agreement. Additionally I have been informed of and understand the Counseling Policies, Client Rights, Limits of Confidentiality and the Notice of Privacy Practices (HIPPA). Copies are available upon request.

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_____ Signature of Client, Guardian or Legal Representative Date_____