EVERGREEN COUNSELING NORTHWEST

INFORMED CONSENT

I understand that Evergreen Counseling Northwest (referred to below as "This Practice") will use and disclose health information about me.

I understand that my health information may include information both created and received by the practice, may be in the form of written records and may include information about my health, history, health status, symptoms, diagnoses and treatments.

I understand and agree that This Practice may use and disclose my health information in order to: make decisions about and plan for my care and treatment; refer to, consult with, coordinate among, and manage along with other care providers for my care and treatment.

I also understand that I have the right to receive and review a written description of how This Practice will handle my health information. This written description is known as a Notice of Privacy Practices. It describes the use and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of This Practice. It also describes my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of This Practice's Notice of Privacy Practices in effect will be posted in the waiting/reception area.

I understand that if I disclose information related to the abuse or endangerment of a minor, vulnerable adult, or a danger to myself or others, that this information will be relayed to the appropriate government agencies.

I understand that no promises have been made to me regarding the results of treatment or of any procedures provided by This Practice. I am aware that I may stop my treatment at any time. I understand that I will be responsible for paying for any services already received. I understand that any consequences resulting from the decision to end therapy are my responsibility.

FEES AND INSURANCE BILLING

Our usual and customary charges are as follows:

Initial assessment:	$150.00
Individual Session:	$125.00
Family Session:	$125.00

You are responsible to pay for all charges incurred. We will bill your primary insurance company, and prompt payment of any outstanding balance is required. Our policy requires that you pay your out-of-pocket costs (such as your deductible and co-pay/coinsurance charges) at the time of the visit. Bills not paid in full within 30 days will be assessed a late fee. Outstanding bills will result in referral to a collection agency or other legal action against you, and any fees we incur due to this process will be added to your outstanding balance. (Fees are subject to change)

By signing below, I agree that I have reviewed and understand the information above.

_____ **Date** _____