Consent for Treatment and Recipient's Rights

Patient Name: _____
DOB: _____

1. **Consent to Evaluate/Treat:** I voluntarily consent that I will participate in a mental health evaluation and/or treatment by Irena Sarovic, LPC. The rights, risks, and benefits associated with the treatment have been explained to me. I understand that treatment may be discontinued at any time by either party. It is encouraged that this decision be discussed before discharge to help facilitate an appropriate plan. Treatment will be conducted within the boundaries of Virginia Law for Professional Counseling.

2. **Benefits to Evaluation/Treatment:** Evaluation and treatment may be administered with psychological interviews, psychological assessment, psychotherapy, as well as expectations regarding the length and frequency of treatment. It may be beneficial to me, as well as the referring professional, to understand the nature and cause of any difficulties affecting my daily functioning, so that appropriate recommendations and treatments may be offered. Uses of this evaluation include diagnosis, evaluation of recovery or treatment, estimating prognosis, and education and rehabilitation planning. Possible benefits to treatment include improved cognitive or academic performance, health status, quality of life, and awareness of strengths and limitations.

3. **Charges:** Fees are based on the length or type of the evaluation or treatment, which are determined by the nature of the service. I will be responsible for all charges and will pay them at the time of service. Initial meeting, a diagnostic evaluation is 90 minutes long and $275. Typical session is 50-60 minutes in length and is $175. Half hour or 90-120 minutes sessions can be arranged if necessary. Initial assessment usually lasts 90 minutes and involves paperwork completion as well as psychosocial and medical history. 48 hours notice is required for cancellations or there will be a $175 charge for a missed session. In situations that require my appearance at a court, there is a non-refundable $2,000.00 fee per full day, which has to be paid a week before the hearing. Official letters to the court and other agencies are charged at my hourly rate.

4. **Confidentiality, Harm, and Inquiry:** Information from my evaluation and/or treatment is contained in a confidential medical record at Ms. Sarovic's office and will not be disclosed without my written permission. Information provided will be kept confidential with the following exceptions: 1) if I am deemed to present a danger to myself or others; 2) if concerns about possible abuse or neglect arise; or 3) if a court order is issued to obtain records.

5. **Right to Withdraw Consent:** I have the right to withdraw my consent for evaluation and/or treatment at any time by providing a written request to the treating clinician.

6. **Expiration of Consent:** This consent to treat will expire 30 days after the last day of treatment, unless otherwise specified.

I have read and understand the above, have had an opportunity to ask questions about this information, and I consent to the evaluation and treatment. I also attest that I have the right to consent for treatment. I understand that I have the right to ask questions of my service provider about the above information at any time.

_____ _____

Signature of the patient **Date**