

INFORMED CONSENT
Lori Zoucha, LMHP, CPC, NCC

Thank you for choosing Lori Zoucha, LMHP, CPC, NCC at LKZ Therapy, LLC for your evaluation and/or counseling services. I am an independent practitioner operating separately from any other professional counselor at New Leaf Therapy Associates, LLC. I realize that starting counseling is a major decision and you may have many questions. This document is intended to inform you of my policies, state and federal laws, and your rights as a client. If you have any questions, please do not hesitate to ask about these or any other concerns you may have. When you sign this document, it will represent an agreement between us.

I, _____, hereby acknowledge and agree to the following:

AUTHORIZATION FOR TREATMENT:

I, the undersigned, consent for Lori Zoucha, LMHP, CPC, NCC to provide mental health therapy and substance use counseling as may be necessary or advisable in my diagnosis or treatment. I understand that a positive outcome cannot be guaranteed. While I understand that Lori Zoucha, LMHP, CPC, NCC will be providing certain therapy and counseling services, I acknowledge that numerous factors can affect the overall outcome and that such therapy and/or counseling services may not be effective in accomplishing the goals or other desired outcomes discussed. I acknowledge and agree that there may be circumstances that presently, or in the future, require treatment or other health care services that are outside the scope of services that can be provided by Lori Zoucha, LMHP, CPC, NCC. With full knowledge of the risks and benefits of engaging in therapy and/or counseling services with Lori Zoucha, LMHP, CPC, NCC, I give my informed consent by signing this document on the following page.

CONFIDENTIALITY:

I acknowledge that information discussed in therapy is held confidential and will not be shared without written permission except under the following conditions: 1) Information shared with consultants, 2) Information (diagnosis, date of service, procedure codes) shared with my insurance company to process claims, 3) Information shared with appropriate authorities if I threaten suicide, 4) Information shared with appropriate authorities if I threaten to harm another person(s), including murder, assault, or other physical harm, 5) Information shared with appropriate authorities if the client is a minor (under 19 years of age) and reports suspected child abuse, including but not limited to neglect, physical abuse, or sexual abuse, 6) Information shared with appropriate authorities if the client reports abuse of elderly, and 7) Information shared with appropriate authorities if the client reports sexual exploitation by a therapist.

State law mandates that mental health professionals are obligated to report these situations to the appropriate persons and/or agencies. Communication between the clinician and the client will otherwise be deemed privileged and confidential as stated under the laws of the state. Having read and understood the above, I agree to the limits of confidentiality.

ASSIGNMENT OF PROFESSIONAL BENEFITS:

I hereby assign all insurance benefits to Lori Zoucha, LMHP, CPC, NCC at LKZ Therapy LLC. This assignment specifically includes, but is not limited to, major medical and disability insurance proceeds and benefits. This assignment also includes proceeds and benefits accruing under any settlement, structured or otherwise, or awarded in judgment for personal injuries caused by a third party. I agree to pay for any and all charges not paid pursuant to this assignment. A photocopy of this assignment shall be as valid as the original.

AUTHORIZED REPRESENTATIVE:

I hereby authorize Lori Zoucha, LMHP, CPC, NCC at LKZ Therapy, LLC to act on my behalf to recover benefit claims, adverse appeal benefit determinations, and to take any action deemed necessary to obtain payment for services provided to me by Lori Zoucha, LMHP, CPC, NCC. I understand that Lori Zoucha may acquire a billing company for this purpose.

OFFICE HOURS:

My availability varies on a weekly basis. When I am not available in the office, please call me and leave a message to contact you. The first priority and my primary concern is your well-being. **In the event of an emergency, please go to the nearest hospital emergency room (ER) for help with your problem.** If I am unavailable, arrangements can be made for you to meet with another counselor within the New Leaf Therapy Associates, LLC office, if absolutely necessary and as available.

APPOINTMENT LENGTH & FEES:

I understand that individual sessions are conducted and billed on a 45- or 60-minute hour, while couples or family therapy are billed on a 60-minute hour. If an appointment runs longer, I understand that I may be charged for the additional time. **I understand payment for professional services are due and payable at the time they are rendered.** Any other arrangement is considered a special arrangement and must be discussed prior to beginning therapy. I understand that delinquent accounts may be referred to a collection agency, at the reasonable discretion of this therapist.

Intake Session (60m)	Individual Session (45m)	Individual Session (60m)	Marital/Couples or Family Session	Group Session (90m)	Chemical Dependency Evaluation
\$175.00	\$120.00	\$150.00	\$150.00	\$50.00	\$200.00

Cash, all major credit cards, Blue Cross Blue Shield Insurance, Midlands Choice Insurance, Aetna Insurance, Midlands Choice Insurance and United Behavioral Health (UBH) Insurance reimbursement are accepted methods of payment.

NO SHOW/CANCELLATION CHARGES:

A missed appointment occupies a significant portion of professional time and keeps this therapist from assisting someone else in need. **Therefore, except in the case of an acute emergency, if I fail to give a 24-hour notice of any cancellation, I agree to pay a fee of \$90.00. This \$90.00 must be paid in full before any future appointments will be scheduled. I agree to keep a current credit card in my file, which will be billed immediately upon a missed appointment without advance notice.** I understand that if I need to cancel an appointment, I should call to inform this counselor so the time may be used appropriately.

I have read and understand these policies. I acknowledge responsibility for all fees incurred.

Client's Signature Date

Guardian's Signature (if applicable) Date

Therapist's Signature & Credentials Date