Sally Markley, LPC
Counseling Services
2561 E. Ft. Lowell Tucson AZ 85716
520-903-8877

Consent for Treatment

I understand that I will be engaging in psychotherapy with Sally Markley, LPC ATR. The purpose of this treatment is so that I feel better or resolve specific life or adjustment problems that have caused me to seek assistance. The primary procedures used by Ms. Markley are “talk” therapy and art therapy, which is the utilization of the creative process of art making to improve and enhance my physical, mental, and/or emotional well-being. I understand that she may also provide general education about mental health conditions or coping strategies. She may also assign “homework” for me to do in between sessions. The potential benefit of treatment is that I will feel better about my life. I understand that a “cure” is not guaranteed and that it is possible that as I work on some issues, I may even feel worse.

I understand that all information I share will be kept confidential, but that this confidentiality is not absolute. In the case of medical emergency, child/elder abuse or neglect, suicidal or homicidal intent, or under court order, clinical information may be released. I also understand that if my treatment is paid for by an insurance company, Ms. Markley will release clinical information to my insurer. In such cases, only that information required for billing will be released.

I understand that as an independently licensed professional counselor in Arizona Ms. Markley is not obligated to receive clinical supervision. However, in an effort to provide services that reflect best practices, she may belong to a consultation group composed of other therapists or may engage a practice consultant with whom she may discuss clinical cases. I understand that if she discusses my case with a consultation group or with a practice consultant I will not be identified by name.

I understand that I can receive a copy of my records or have a copy of my records provided to another person by completing a Release of Information form.

I understand that I have the right to participate in treatment decisions and that Ms. Markley and I will together develop and periodically review and revise a treatment plan which will identify my goals for treatment as well as the means of achieving those goals. I understand that I have the right to refuse any recommended treatment and that I may withdraw my consent to treatment at any time with no consequences.

I understand that Ms. Markley utilizes a billing company to bill my insurance company at the standard fee of $120 per 50 minute session and will accept insurance payments as partial payment towards this fee. I will be responsible for paying the agreed upon co-pay for each session covered by the insurance. Any excess insurance payments to Ms. Markley will be credited to my account and any insurance payments sent to me will be remitted to Ms. Markley up to the amount of my unpaid balance. I understand that I will be billed for cancelled sessions unless I give Ms. Markley 24 hour notice and that since most insurance companies will not pay a missed session fee I will be responsible for paying this fee. I understand that my insurance company is under contract with me and/or my employer and not with Ms. Markley, that I am ultimately responsible for all charges incurred for therapeutic services, and that Ms. Markley may use a collection agency if fees are not paid within a reasonable time frame. I may pay by check, cash or charge card. I acknowledge that if I choose to pay with a charge card, I will be charged an additional fee of 2.75% per charge.

I have read the above information, had the opportunity to ask questions, and consent for treatment.

Signature: _____ Date: _____

Witness: _____ Date: _____