Jennifer Worth, MSW, LCSW, LLC

CONSENT FOR TREATMENT

I understand that I am a client of Jennifer Worth, MSW, LCSW, LLC, independent healthcare practitioner. My care is the exclusive responsibility of Jennifer Worth, MSW, LCSW.

Cooperation with treatment:
In order for therapy treatment to be effective, I must come to scheduled appointments unless there are unusual circumstances. I understand and agree to cooperate with home assignments that are intended for me. If I have trouble with any part of my treatment program, I will discuss it with my therapist.

Cancellation Policy
I understand that if I cancel I will not be charged. If I do not show for my appointment and do not call to cancel I will pay the no show fee of $75.00 for my treatment session. I understand that I will have to pay the $75 fee before my next appointment. In addition, I understand that if I no show/no call my appointment any future scheduled appointments will be canceled, and I will be scheduled wherever there is an opening.

No warranty: I understand that there are no guarantees regarding a cure for or improvement in my condition. I understand that my therapist will outline and discuss goals of therapy treatment for my condition and will discuss treatment options with me before I consent to treatment.

Informed consent for treatment:
The term "informed consent" means that the potential risks, benefits, and alternatives of mental health therapy treatment have been explained to you. The therapist provides a wide range of services and I understand that I will receive information at the initial visit concerning the treatment and options available for my condition.

Potential risks: Since psychotherapy therapy can require clients to discuss issues intimate in nature, I may experience symptoms such as anxiety, sadness, and guilt. I agree to contact my mental health therapist with any concerns.

Potential benefits: I may experience an improvement in my symptoms. I may gain a greater knowledge about managing my condition and the resources available to me.

Alternatives: If I do not wish to participate in the therapy program, I will discuss my medical or pharmacological alternatives with my physician or primary care provider.

Release of medical records:

Due to the business of Jennifer Worth, MSW, LCSW, LLC being located in the Foundational Concepts offices, I authorize the release of my medical records to Foundational Concepts. All therapists and staff at Foundational Concepts are required to keep client personal health information confidential.

CONDITIONS & CONSENT FOR TREATMENT

Financial and insurance responsibilities:
I agree to pay for my treatments at time of service, by cash, check, or charge card unless other mutually agreed upon arrangements have been made. I understand it is my responsibility to call my insurance

company ahead of time, and obtain any pre-authorization that is necessary, and get an estimate of my benefits. I understand my therapist will submit my claim to my insurance company.

I have read the above information and I consent to evaluation and treatment.

Print Name	Date
Patient or Guardian Signature	Date