Laurie Friesen, LMFT
20412 Brian Way, Suite 1
Tehachapi, CA 93561

CONSENT FOR TREATMENT
OFFICE POLICIES

CLIENT NAME:________________________________ DATE OF BIRTH:__________________

I, _________________________________authorize and request that my therapist, **Laurie Friesen, LMFT**, provide psychological examinations, assessment, interventions and/or diagnostic procedures that now or during the course of my or my child's care as a client are advisable. The frequency and type of assessment will be decided between my therapist and me.

CONSENT TO TREATMENT: I understand my participation in the counseling, educational and case management services provided by Laurie Friesen, LMFT is voluntary and all activities are to be done with my consent. Participation in these services may be terminated by me or Laurie Friesen, LMFT at any time for any reason whatsoever. If services are terminated, referrals to other providers will be supplied.

CONFIDENTIALITY: All information disclosed within sessions, including that of minors is confidential and may not be revealed to anyone without written permission except where disclosure is permitted or required by law. Disclosure may be required in the following circumstances:

- When there is reasonable suspicion of abuse to a child, dependent, or elder adult.
- When the client communicates a serious threat of bodily injury to others.
- When the therapist has reasonable belief that the client may be a danger to themselves or others.
- When disclosure is otherwise required by law.
- I receive regular professional consultation. In such cases, neither your name nor any identifying information about you is revealed.

I understand that the purpose of these procedures will be explained to me and be subject to my verbal agreement.

I understand that there is an expectation that my child or I will benefit from this assessment and/or interventions, but there is no guarantee that this will occur.

I understand that maximum benefit will occur with consistent attendance and, that at times, I may feel conflicted about my therapy as the process can sometimes be uncomfortable.

RELEASE OF INFORMATION: I authorize Laurie Friesen, LMFT, to release to my health insurance program(s) and its agents any information necessary to process claims for services rendered to me.

EMERGENCY TREATMENT: My regular office hours are Wednesday and Thursday from 10:00 am to 7:00 pm. However, you may leave a voicemail or text **(661) 977-6514** on any day of the week and can expect a response by the next business day. If this is a crisis in which you need to speak to someone immediately, please call the Psychiatric Emergency Center at (661) 868-8037 or the crisis line at (800) 991-5272. **If this is a life threatening emergency, please call 911.**

ADDRESS CHANGES: Please advise us if you change your address, telephone number, place of employment, or insurance coverage or companies.

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PAYMENT: The client (or parent if minor) is financially responsible for services provided. Laurie Friesen, LMFT requires the financially responsible party to provide a form of payment. Any co-pays, late cancellation fees, missed appointment fees, or any other fees not covered by your insurance will be paid with the form of payment on file.

INSURANCE BILLING: Billing your insurance is a courtesy of my office. If payment is not received after 90 days of billing, future services will be on a cash basis until insurance discrepancies are resolved.

CANCELLED/MISSED APPOINTMENTS: A scheduled appointment means that time is reserved only for you. **If an appointment is cancelled with less than twenty-four (24) hours' notice, you will be billed $25; no call no shows will be billed $65.00 with the form of payment on file charged.** _______________(initial)

TO CANCEL AN APPOINTMENT, PLEASE LEAVE A MESSAGE WITH MY OFFICE AT (661) 977-6514.

I have read and fully understand this Consent for Treatment form and office policies.

_______________________________________ _______________________________________
Client/Parent/Guardian Name (print) Client/Parent/Guardian Signature

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Date