B. Danielle
Counseling & Coaching

3754 Lavista Rd #200, Tucker, GA 30084
404.490.0081 | itsbdanielle@gmail.com |www.bdanielle.com

CONSENT TO TREATMENT

I, _____, consent and authorize B. Danielle, LLC services to be rendered as deemed necessary by my provider. I understand that that treatment success or progress is not guaranteed. I acknowledge that even though there are many benefits to treatment, there are also potential risks associated. I consent to being an active, engaged, cooperative participant within treatment for the best results. I will also provide feedback to B. Danielle, LLC as I deem necessary to resolve issues, as well as improve therapeutic rapport. I acknowledge at any time that I can discontinue treatment, as well as B. Danielle, LLC reserves the right to discontinue services with me.

I understand that B. Danielle, LLC will use and disclose my protected health information when required by federal, state or local law. There are certain situations in which a therapist is required by ethical standards to reveal information obtained during therapy to persons or agencies, even if I do not give permission. These situations are as follows: (a) If I threaten grave bodily harm or death to myself or another person; (b) if I report knowledge of physical or sexual abuse of a minor child (under 18) or of an elder (over 65) or any sexual conduct/contact with a minor (under 18); (c) if the therapist is required by a court of law to turn over records to the court or if the therapist is ordered to testify regarding those records.

AUTHORIZATION FOR DISCLOSURE OF INFORMATION

I, _____, hereby authorize B. Danielle, LLC to release or disclose information regarding my treatment, financial, and/or business record by telephone or writing for the following purposes:

- ***Treatment*** such as, but not limited to, providing, coordinating and/or managing mental health care, employee assistance program services, and related services of B. Danielle, LLC.
- ***Financial*** means activities such as coordinating and collecting payment for services, and seeking reimbursement from the identified responsible party, insurance, employee assistance program, and/or another third-party payer.
- ***Business*** includes all administrative aspects of maintaining and operating B. Danielle, LLC.

RELEASE OF INFORMATION

☐ Information is not to be released to anyone.
☐ I authorize the release of information including the diagnosis, records; examination rendered to me and claims information.

This information may be released to:

☐ Spouse _____ ☐ School _____

☐ Child(ren) _____ ☐ Other _____

This Release of Information will remain in effect until terminated by me in writing. This authorization may be revoked or modified at any time except to the extent those actions have already been taken. To cancel or modify this authorization, the patient and/or responsible party must do so in writing to B. Danielle, LLC.

_____ _____

Signature of client (or representative) **Date**

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POLICY AND PROCEDURE

Please initial on the lines below to acknowledge that you have read and understand the policies. B. Danielle, LLC reserves the right to modify policies and procedures without notice.

_____ **INSURANCE:** I understand that I am responsible to know my insurance benefits, which includes copayment, deductibles, and coinsurance. I am responsible for updating B. Danielle, LLC of any insurance changes prior to the appointment. I understand that B. Danielle, LLC will file insurance claims as a courtesy to me, but not responsible for determining insurance reimbursement rates, or my final payment amount. If I have any issues with my claim, I am responsible for addressing those concerns with my insurance company directly.

_____ **PAYMENT FOR SERVICES:** I understand that I am responsible for the full payment of services rendered at the time of service. This includes self-pay, copayments, deductibles and co-insurance amounts. B. Danielle, LLC reserves the right to change the cost of appointments without notice. Payments can be made via Cash App, PayPal, Venmo, Cash, and Credit Card. I understand that delinquent accounts will be charged 1.5% interest each month. Account balances must be paid ***before*** scheduling another appointment.

_____ **APPOINTMENTS:** I understand that I will be charged a LATE CANCELLATION fee of $50 if I fail to give at least 24-hour notice prior to cancelling my appointment. I understand that I will be charged a NO-SHOW fee of $100 if I fail to show for my appointment. Fees for late cancellation and no-show are due ***before*** scheduling another appointment. B. Danielle, LLC reserves the right to change the cost of appointments and fees without notice. B. Danielle, LLC reserves the right to reschedule my appointment if I am more than 15 minutes late. I understand that if I am late for an appointment, the session will still end at the scheduled end time. I understand that if I no-show and/or late cancel three times, B. Danielle, LLC reserves the right to terminate me from the practice.

_____ **FORMS**, **LETTERS & RECORDS:** I understand that B. Danielle, LLC will only fill out forms or write letters after I have been seen ***at least 3 times consecutively***, and subject to fees based on required time to complete out of scheduled appointments. B. Danielle, LLC reserves the right to decline filling out requested forms or letters. Also, I understand that I may request medical records, with a cost of **$0.25 per page**, and **$25 administrative fee**. Medical records will be provided free of charge per request of another medical provider for continuity of care.

_____ **AFTER HOURS/EMERGENCY:** I understand that B. Danielle, LLC does not have a live 24-hour answering line. If I leave a voicemail or send an email, I understand the call and/or email will be returned during regular business hours, which are Mon-Fri 9am-5pm. If I need to contact B. Danielle, LLC after hours or have a crisis, I will call 9-1-1 or the Georgia Crisis & Access Line at 1-800-715-4225 for more immediate assistance.

_____ **TERMINATION OF CARE:** I understand that I can terminate services with B. Danielle, LLC at any time. If I have not been seen for the past 3 months, B. Danielle, LLC will consider this self-termination. I acknowledge that B. Danielle, LLC reserves the right to terminate treatment or other services with me at any time.

_____ **EAP ONLY:** For Employee Assistance Program clients, policy and procedures may be different depending on your EAP provider. You will receive a separate contract outlining the policy and procedures for your provider. You will be held accountable for following those rules and regulations. In addition, B. Danielle, LLC will file your approved sessions with your EAP provider. You will have no out of pocket costs for the approved sessions.