837 S. Lapeer Rd, Ste 205, Oxford MI 48371

CONSENT FOR TREATMENT / RECIPIENT RIGHTS FORM

I consent to and am voluntarily seeking treatment at GLIO Counseling Group, PLC. In the event that the patient is a minor, I represent that I have the right and authority to authorize treatment and hereby authorize a therapist within GLIO Counseling Group, PLC to provide services to that minor.

I understand the following:

- Information is considered confidential and my right to privacy shall be respected by the staff at GLIO Counseling Group, PLC.
- Promises and / guarantees cannot be offered regarding the outcome of treatment.
- Termination of treatment is ideally an agreement between the therapist and client; however, the client has the freedom to discontinue treatment at any time.
- I understand that treatment may entail a psychiatric evaluation conducted by a psychiatrist (Therapist is able to provide referral, if needed).

I agree to the following:

- I understand that my therapist is not responsible for any risk or complications resulting from counseling services obtained at GLIO Counseling Group, PLC.
- To respect the rights and privacy of other clients at GLIO Counseling Group, PLC.
- Work with the assigned therapist in developing my treatment plan and follow the treatment plan.

Cancellation Policy:

- If you fail to cancel a scheduled appointment, we cannot use this time for another patient, and you will be billed a $50 no show/ late cancel fee.
- A Credit Card is required to keep on file in order to cover this fee should a No Show/Late Cancel occur.

EAP Policy:

- Any No Show will result in Immediate Discontinuation of all future appointments with Therapist. Should your EAP policy allow it you will be charged a $50 cancellation fee. EAP will be notified of your No Show.

Charges:

I understand;

- That I will be responsible for any charges not covered by insurance, including co-payments and deductibles.
- That my Credit Card on File will be used to cover the charges stated above.

I have read, understand and agree to all the above, have had an opportunity to ask questions about this information, and I consent to evaluation and treatment. I understand that I have the right to ask questions of my service provider about the above information at any time.

Patient Signature ________________________________ Date ___________________

Parent/Guardian's Signature ________________________________ Date ___________________

Therapist Initials _____________