

Eva Hudlicka, LICSW, MSW, PhD – Psychotherapy

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CONSENTS FORM

_____ Client name _____ Date of Birth

The authorizations and consents listed below are required before we can begin treatment. Please be sure to understand each consent or authorization, and do not hesitate to ask for any clarifications.

_____ CONSENT TO TREATMENT: I consent to receive psychotherapy
Initials from Eva Hudlicka, LICSW. I understand that this consent is entirely voluntary, that I do not have to accept any treatment option offered to me, and that I may withdraw my consent at any time for any reason.

_____ THERAPIST-CLIENT SERVICE AGREEMENT: I have read,
Initials understood and agree to the terms included in Eva Hudlicka’s Therapist-Client Service Agreement.

_____ CONFIDENTIALITY: I understand the confidentiality policies, as
Initials well as its limitations, as described in the Therapist-Client Service Agreement and as explained verbally by Eva Hudlicka, LICSW.

_____ LENGTH AND DURATION OF TREATMENT: I understand that
Initials standard individual therapy sessions are 50 minutes long (unless otherwise specified by my insurance policy). I understand that the duration of treatment depends on many factors, and that short-term treatment typically lasts between several weeks to several months.

_____ DESCRIPTION OF PRIVACY POLICIES: I have read and understand the
Initials Notice of Privacy Policies.

_____ CANCELLATION AND MISSED APPOINTMENTS POLICY: If I
Initials miss an appointment or provide fewer than 24 hour notice, I agree that I will automatically be charged a cancellation fee of \$45.00. I understand that my insurance does not cover this expense and and that a payment will be due during the next session.

Initials EMAIL or TEXTING CONTACT BETWEEN THERAPIST & CLIENT:
If I decide to communicate via email or text, I understand that I am doing so with the full understanding that this communication may not be secure, that email or text may get lost or delayed, and that sending an email or a text message is no guarantee of its receipt.

Initials FINANCIAL OBLIGATION: I agree to pay for all services provided, regardless of whether there is insurance coverage. If I am using insurance to pay for services, I agree to be familiar with the specific terms and limits of my insurance coverage. Unless a payment plan has been arranged at the beginning of treatment, I agree to pay any self-pay fees, insurance co-payments, and/or co-insurance and deductibles by the end of each session.

Initials ASSIGNMENT OF INSURANCE BENEFITS AND BILLING AUTHORIZATION: I authorize the payment of my insurance benefits directly to Eva Hudlicka, LICSW, for psychotherapy services provided. I also authorize Eva Hudlicka, LICSW to bill my insurance company for her services and to release my health information necessary to process insurance claims associated with my psychotherapy.

Initials PRIMARY CARE PHYSICIAN: Please check only ONE of the following:

- You are authorized to contact my primary care physician whose name and address are shown below to discuss the treatment that I am receiving while under your care and to obtain information concerning my medical diagnosis end treatment. A separate Release of Information would be required.
- You are NOT authorized to contact my primary care physician whose name and address are shown below to discuss the treatment that I am receiving while under your care and to obtain information concerning my medical diagnosis end treatment. I am providing the name/address of my primary care physician only for your records.

ACKNOWLEDGMENT: My initials above and my signature below acknowledge the terms and conditions herein.

Signature of Client or Guardian

Date