J L Fristad, PLLC
512 Herndon Parkway, Suite F
Herndon, VA 20170-5244
703-980-9715

Consent for Services

Client Name: _____ MR#: _____

J L Fristad, PLLC will make every effort to provide a safe, confidential, client-centered environment for clients receiving therapy. This Consent for Services form describes some of the specific actions/activities by J L Fristad, PLLC in support of that safe, confidential, client-centered environment and seeks the above client's consent for treatment.

Confidentiality Policy

Clients will be provided with a Notice of Privacy Practices during their initial visit. This Notice of Privacy Practices describes the client's rights and J L Fristad, PLLC's responsibilities regarding the confidentiality of client health information.

Availability

Sessions, other than the intake session, are scheduled and limited to 50 minutes. Intake sessions are scheduled for one hour. Because other clients will be waiting for their appointment, these time limits with be strictly adhered to except in emergency circumstances.

It is important to me to act as an advocate for you in a time of crisis. In cases of emergencies occurring during times when I am not available, please call 911 and/or go to the nearest emergency room. Please leave a message for me advising that you have called 911 and/or that you have gone to the emergency room, so I can follow up with you when I am next available.

By consenting to treatment at J L Fristad, PLLC, clients acknowledge and accept this schedule of availability.

Fees

We will discuss fees at the beginning of the first session. Payment, by check, cash or money order, must be made at the end of each session.

J L Fristad, PLLC
512 Herndon Parkway, Suite F
Herndon, VA 20170-5244
703-980-9715

This practice will accept payment for counseling services from a limited number of insurance companies. Please ask for a copy of our current list of insurers.

Clients seeking insurance reimbursement are strongly encouraged to contact their insurance carrier before beginning therapy to determine the level of payment that the insurer will approve for mental health services. Co-payments for the difference between what the insurance company will reimburse and the cost per session must be made at the end of each session. If co-payment amounts have not been determined in advance, full payment for the session will be required at the end of the session.

Clients who have insurance from providers not accepted by J L Fristad, PLLC, or who have out of network mental health coverage will need to pay the full session fee at the end of the session and seek reimbursement on their own through their insurance company. J L Fristad, PLLC, will provide a bill for the client to submit to their insurance company for reimbursement.

Clients will be billed at 50% for no-shows to scheduled appointments. To avoid this fee, cancellations or re-scheduling of appointments must occur at least 24 hours in advance of the scheduled appointment.

By consenting to treatment by J L Fristad, PLLC, clients are accepting this fee policy.

Goals for Therapy

Counseling is a process and the goal of counseling is to achieve overall wellness in areas of concern or dissatisfaction in a client's life. Clients will be encouraged to grow as an individual, develop insight into personal struggles, and learn strategies to achieve desired goals. In order for therapy to be effective, it is necessary for clients to attend all scheduled counseling sessions and to actively participate in the therapeutic process. By consenting to treatment by J L Fristad, PLLC, clients are committing to active participation and appearance at all scheduled appointments to the best of their ability.

Consent for treatment

I hereby authorize J L Fristad, PLLC, to administer mental health services which may include psychotherapy, psychoeducation, and/or couples/family counseling. Each adult participant in couples/family counseling will be required to complete a separate consent form. No copies of records for couples/family counseling will be provided to any participant unless all participates authorize release of those records, in writing, or unless a court otherwise orders release of those records.

During therapy I may receive Cognitive Behavioral, Strengths-Based and other therapeutic models to assist me in attaining my treatment goals.

J L Fristad, PLLC
512 Herndon Parkway, Suite F
Herndon, VA 20170-5244
703-980-9715

I understand that this consent may be revoked by me at any time throughout the treatment period and that revocation shall be effective upon communication of same to J L Fristad, PLLC. I acknowledge that there have been no guarantees or assurances made to me regarding the results of the services provided by Janice Fristad, LCSW, or J L Fristad, PLLC.

Client Statement: By signing below, I acknowledge that I have read and fully understand the conditions of this Consent for Services and agree to be bound by same.

_____ _____ Date: _____
Client Signature

_____ Date: _____
Parent/Legal Guardian Signature

_____ Date: _____
Janice Fristad, LCSW, ACSW, C-ASWCM
Therapist and Director of J L Fristad, PLLC