## INFORMED CONSENT:

**Client Name** _____

Thank you for choosing Finding Balance, Ltd. We realize that starting counseling is a major decision and you may have many questions. This document is intended to inform you of our policies, State and Federal Laws and your rights. If you have other questions or concerns, please ask and we will try our best to give you all the information you need. The owner of Finding Balance, Ltd., Reem Cutinello, LCSW, has earned a Masters Degree in Social Work from the University of Illinois at Chicago. She is licensed by the State of Illinois as a Licensed Clinical Social Worker. Counselors of Finding Balance, Ltd. practice standard therapy for most conditions. Treatment practices, philosophy and plan limitations and risks will be discussed with you today.

## FINANCIAL INFORMATION:

We request that you pay the balance due for counseling services at the end of each session. If a balance of monies owed exceeds 60 days, the client will be charged 1.5% interest per month (18% APR). In the event that an account is overdue, it will be turned over to our collection agency. The client will be held responsible for any collection fee charged to our office to collect any debt that is owed. Co-payments are due at the end of each session. We sincerely appreciate your cooperation.

_____ _____

**Signature(s)** **Date**

*Lastly, if you need to cancel or reschedule an appointment, please give **24 business hours advance notice**, otherwise you will be billed at the hourly rate. We sincerely appreciate your cooperation and at any time you have any questions regarding insurance, fees, balances or payments please feel free to ask. You may have a copy of this form if requested.*

_____ _____

**Signature(s)** **Date**

## COORDINATION OF TREAMENT:

It is important that all health care providers work together. As such, we would like your permission to communicate with your primary care physician and/or psychiatrist. Your consent is valid for one year. **Please understand that you have the right to revoke this authorization, in writing, at any time by sending notice. However, a revocation is not valid to the extent that we have acted in reliance on such authorization**. If you prefer to decline consent no inform will be shared.

_____ **Yes, you have my consent to inform/contact my physician**
Initials

_____ **No, you do not have my consent to inform/contact my physician**
Initials

**PHYSICIAN NAME:** _____

**CLINIC:** _____

**ADDRESS:** _____

**PHONE NO.:** _____

_____ _____

**Signature(s)** **Date**