Consent for Treatment & Agreement for Working Relationship

Please read and initial next to each statement, indicating your understanding and agreement, and sign below. Please ask for clarification on anything you don't understand. .

_____ I consent to be involved in counseling, psychotherapy, behavioral health treatment, creative arts therapy, authentic movement, and/or personal growth work with Lisa Fladager.

_____ I have been given information about her training, credentials, and methods of working and understand that I have been given ample ongoing opportunity and permission to ask questions or clarify anything I have concerns about.

_____ I agree to pay the fee of 130 dollars per 60 minute hour, prorated for longer sessions, due at the time of service, unless another payment arrangement has been made. (Arrangement: _____)

_____ I understand that if I fail to make payments in a timely matter that a finance charge maybe apply, or a collection agency or small claims court may be options for collecting payment. This may potentially involve a disclosure of my name, nature of services provided, and amount due.

_____ I understand that I am required to provide 24 hours notice of cancellation or I will be responsible for paying the full fee for my missed session.

_____ I understand that Lisa Fladager is a solo practitioner, and is not in a group practice with any other behavioral health provider, even though she may share practice space with them or occasionally engage in a teaching or co-facilitation relationship with them.

_____ I understand that Lisa Fladager is bound by Washington state law and professional obligation to report to the pertinent authorities instances that involve suspected abuse of children or vulnerable adults, or imminent danger to self or others. Such instances may warrant actions on her part that could supersede my rights to confidentiality.

_____ I understand that I am eligible for mental health crisis services 24 hours a day, 365 days a year, by calling the VOA Care Crisis Line at 1-800-584-3578. This service is free to me.

My signature below indicates that I understand and agree to the above, and that I received and take responsibility for reading the following information, which will be provided to me no later than our first session:

“Clinician Disclosure Statement”
“What to Expect from your Licensed Mental Health Counselor”
"HIPPA Disclosure”

_____
Client signature Date

_____
Clinician signature Date