INNER LIGHT, LLC
GENERAL INFORMED CONSENT DOCUMENTATION
1724 LAUREL AVE HUDSON, WI 54016
(P) 715-222-2260 (F)715-386-2858

This Informed consent effective for 12 months from the time consent is given. The right to withdraw the informed consent can be done in writing at any time.

I, the undersigned , acknowledge that the following has been explained to me and my questions have been satisfactorily answered: 1.) Cost of therapy, insurance coverage, co-payments, co-insurance, private pay options, and no show policy. 2.) Client's rights explained regarding confidentiality, access to records, and the following: a) the benefits of the proposed treatment and services, b) the way the treatment is to be administered and the services, c) the expected treatment side effects or risks of side effects which are reasonable possibility, d) alternative treatment modes and services and the probable consequence of not receiving proposed treatment and services.
3.) Grievance policy and procedure, 4.) Emergency arrangements, 5.) Written copy of 1-4.

_____ _____

Client Date Parent or Guardian Date

Fee Arrangement: In order to accommodate the needs and requests of my clients, I have enrolled in a number of insurance programs and we file insurance forms. I make every effort to work with your insurance company, but clients are always financially responsible for received services.

My fee for the initial intake is $200.00. Ongoing psychotherapy costs are $150.00 for a 45 minute session and $225.00 for a 50-60 minute session. My Sliding scale fee is $85.00 an hour. A no show fee of $75.00 will be assessed when a proper cancellation notice is not received. Other work and associated costs are not covered by insurance such as reports and will be billed at $200.00 per hour and are payable in advance.

Client/Parent/ Guardian_____Date_____

Assignment of Benefits: I authorize payment of benefits to Inner Light, LLC, for services provide to myself and/or dependents. I further understand that ultimately I am financially responsible for services rendered if the insurer denies reimbursement and and responsible for an deductible, co-pay, or co-insurance requirements.

Client/ Parent/ Guardian_____Date_____

Notice of Privacy Practices: Your signature below signified at that you have received the agreement and agree to it's terms and also services as an acknowledgement and you have received the HIPPA Notice Form. I understand that consent can be revoked or revised at any time in writing. I also understand that I have the right to access my records upon request.

Client/ Parent/ Guardian_____Date_____

Release of Records: I understand that my mental health records are protected by Federal and State Laws. A copy of this authorization will be treated in the same manner as an original. I herby authorize Inner Light, LLC, to release information, if requested to m insurance company, and it's managed care companies, regulatory agencies, health care provider and others who need this information to pro form their duties (such as submitting insurance claims) as specified under applicable laws, on behalf of of myself and/or my dependents. I also understand that Inner light, LLC has a Business Manager that helps facilitate the business process

Client/ Parent/ Guardian_____Date_____

Outside supervision: I also understand that Carolyn P. Fuchs is and analytic candidate with the Minnesota Institute for Psychodynamic Psychotherapy and is required by that program to case clients. I agree if needed that my case can be cased with a Supervising analyst.

Use of Electronic Media_____Date _____

Texting]
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Client/ Parent/ Guardian_____Date_____

Witness_____