**Meridian Counseling Center**

**38052 Meridian Avenue/ PO Box 2398, Dade City, FL 33526**

**Phone (352) 518-5232 / Fax (352) 518-9458**

**Intensive Therapy Agreement**

**Consent for Treatment**

I hereby give my consent for Emily Gilbert, LCSW/Trauma Treatment of Pasco, PLLC/DBA/Meridian Counseling Center to provide Intensive Therapy and/or Counseling as needed for therapeutic intervention appropriate to the designated client(s) including but not limited to Marriage, Couples, and Families. Every client is treated with the highest standard of ethical and professional treatment typical to effective therapies. Although there is an expectation of benefit, there are no guarantees. Outcomes are dependent on my cooperation, effort, and my ability to incorporate change into my life. I have the right to terminate the therapeutic relationship at any time that I desire without fault, and with the understanding that I am responsible for payment of all outstanding charges. I understand my records may be released to current or future doctors or therapists in this practice.

**Financial Agreement**

I agree to participate in services provided at Meridian Counseling Center. Although I am not bound to complete services, in good faith, I agree to participate in sessions and keep scheduled appointments. I am aware that although exact times may vary, most **sessions will be approximately 3 hours and the fee per session is $350.00**. I understand that payment is due upon services rendered. **Where insurance is applicable, half the cost must be paid at the time of services rendered** and the designated insurance company will be billed through Meridian Counseling Center.

**Appointment Agreement**

We understand your time is valuable, and therefore make it a priority to inform you of any changes in your appointment time with Emily Gilbert, LCSW/Trauma Treatment of Pasco, PLLC. In the same respect, we would like for you to be aware that when you schedule an appointment that time is reserved solely for you. Because of this, we ask that you extend the same courtesy to us that we extend to you by giving ***at least 24 business hours notice of any appointment that you will not be able to attend*.** Please understand that by canceling your appointment with sufficient notice you make it possible for us to efficiently meet the needs of other clients. Also, be aware that a fee is charged for late cancellations and for failure to show up for your appointment, and that these fees are your responsibility, not your insurance company's. Fees are as follows **$150 for a late** **cancellation and up to $350 for a no-show**. While you have the right to terminate your therapeutic relationship at any time without fault, you remain responsible for any outstanding balance you should have with Meridian Counseling Center. By signing below you are agreeing that you have read and understand the above contract guidelines. If you have any questions, please ask before signing the agreement to ensure there are no miscommunications.

**Insurance Agreement**

I hereby give consent to Emily Gilbert, LCSW/Trauma Treatment oF Pasco, PLLC/DBA/ Meridian Counseling Center to provide whatever treatment deemed necessary to the above patient. **I understand that I am responsible for charges incurred for services. I understand I am responsible for charges not covered by the insurance policy** and should it become necessary to collect these charges through an attorney or other collection process, I shall be responsible for all court costs, attorney’s fees, and a collection expense of no more than 30% of the referred balance. I hereby request payment of authorized insurance benefits for me to be paid directly to Meridian Counseling Center for any services furnished me by Emily Gilbert, LCSW located at Meridian Counseling Center. I authorize Emily Gilbert, LCSW, and Meridian Counseling Center to release to my insurance carrier and its agents any information concerning health care, advice, treatment, or supplies provided me, needed to determine these benefits payable for related services. I understand this is a lifetime authorization. I agree to pay copay fees at the time of service.

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Signature of Responsible Party Date

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Print Name