NANCY LOWRIE & ASSOCIATES, LLC
CONSENT FOR TREATMENT - PROFESSIONAL SERVICES AGREEMENT

I understand that the effectiveness of psychotherapy depends on the efforts of the patient as well as the practitioner and I promise to make my best effort to comply with those procedures. I understand that I am entering into a therapeutic relationship with a licensed professional. I understand that this professional may recommend that I complete other forms of treatment; i.e.; psychological testing, psychiatric evaluation, or clinical homework. I understand that the effectiveness of psychotherapy/counseling depends on the efforts of the patient as well as the practitioner and I promise to make my best effort to comply with those procedures, assignments, etc. I understand that I am fully responsible for the outcome of my treatment and that results may vary based on adherence to such recommendations. I further understand that Nancy Lowrie & Associates LLC is making no guarantee about the outcome of treatment, as the field of psychotherapy is based on individual response.

I understand that regular attendance will provide the maximum benefits but that I am free to discontinue treatment at any time. If I decide to do so, I will notify Clinician at least two weeks in advance so that effective planning for my continued care can be implemented. **I will notify Clinician at least 24 hours in advance if I will be unable to attend any session. If I fail to make such notification, I will be charged the full amount of the session, which will not be reimbursed by my insurance company and I will be solely responsible for these charges.**

I further understand that conversations with the Clinician will almost always be confidential. I understand that a mental health professional, by law, must report actual or suspected child abuse or neglect or elder abuse or neglect to the appropriate authorities. In addition, the Clinician has the legal responsibility to protect anyone that the patient may threaten with violence, harmful or dangerous actions (including those to myself) and may break confidentiality of our communication if such a situation arises. I understand that the mental health professional will make reasonable efforts to resolve these situations before breaking confidentiality.

I request that Nancy Lowrie & Associates, LLC submit my bill to the insurance company which I have listed on the Client Intake Form, and I grant permission to the Clinician and the Billing Service to release such confidential information as is necessary to obtain payment from the insurance company. In the event that my insurance company fails to observe Ohio prompt payment standards or otherwise fails to adhere to appropriate business standards, I grant permission to share information related to my insurance with the Ohio Department of Insurance.

I understand that I am financially responsible for the cost of the psychological services or any portion of the fees not reimbursed by my health insurance. If my mental health care is provided under the terms and conditions of a managed health care program, which the Clinician is contracted, my financial responsibility may be limited to the terms of the contract. I understand that I am financially responsible for the cost of the psychological services or any portion of the fees not reimbursed by my health insurance. Failure to pay these bills may result in collection procedures (including court proceedings) being taken against me by Nancy Lowrie & Associates LLC or a collection agency contracted by same to collect these bills. I also understand that I will be responsible for any additional charges incurred through the use of a collection agency contracted by Nancy Lowrie & Associates LLC to collect these bills. I also understand that I will be responsible for fees incurred through the use of a collection agency or the filing of a court action including attorney and filing costs.

I understand that professional services will be rendered to me by Nancy Lowrie & Associates LLC clinicians, assessment fee is $125.00, additional sessions of 45-50 minutes billed at $105.00, and up to 75 minutes sessions billed at $140.00. Fees may be billed for extra services. **Insurance does NOT reimburse extra time spent during sessions. Phone calls (including coordination of care and client calls) after 10 minutes are billed at a prorated fee of $105.00 per hour. Self-pay, groups, CD and SAP Assessments are billed to the client and not to insurance. Charges are per practice terms and subject to change.**

ASSIGNMENT & RELEASE: I HEREBY ASSIGN MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO NANCY LOWRIE & ASSOCIATES LLC. I AM FINANCIALLY RESPONSIBLE FOR NONCOVERED SERVICES AND DEDUCTIBLES. I ALSO AUTHORIZE NANCY LOWRIE & ASSOCIATES LLC TO RELEASE ANY INFORMATION REQUESTED TO MY INSURANCE COMPANY, MANAGED CARE COMPANY, THIRD PARTY ADMINISTRATOR OR ANY OTHER PERSON OR ORGANIZATION NECESSARY IN THE SUBMISSION, PROCESSING AND APPROVAL OF CLAIMS. MY SIGNATURE BELOW INDICATES THAT I HAVE AGREED TO ALL THE ABOVE TERMS OF THIS CONSENT FOR TREATMENT/PROFESSIONAL SERVICES.

CLINICIAN **DATE**

CLIENT'S SIGNATURE OR PARENT/GUARDIAN/REPRESENTATIVE **DATE**

WITNESS **DATE**