

## Consent to Treatment

I acknowledge that I have received and read the “Information for Clients” document provided by Alina Tsirelson, LPC. I have had the opportunity to ask questions and understand that I may ask my provider any questions at any time.

I consent to participate in treatment with Alina Tsirelson, LPC. I understand that developing a treatment plan with my therapist and regularly reviewing progress toward treatment goals is in my best interest. I agree to play an active role in this process and to work to the best of my ability to achieve these goals.

I understand that no promises have been made to me regarding the results of treatment or of any specific procedures provided.

I understand that I may stop treatment at any time. I will remain responsible for payment for all services already received. I understand that stopping treatment may have consequences, such as needing to answer to the court if treatment was court-ordered.

**I have read and understand the cancellation and missed appointment policy, which is as follows:**

- I agree to cancel appointments with at least 48 hours’ notice at no charge.
- Cancellations made with less than 48 hours but more than 24 hours notice will be charged a flat fee of \$50.
- Cancellations made with less than 24 hours notice, or failure to show without notice, will be charged the full session rate — \$180 for private pay, or the insurance-allowed amount for insured clients, unless a different rate has been agreed upon in writing.
- Missed appointment fees are not covered by insurance.

I understand that part of my therapy expenses may be covered by my health insurance and that I am responsible for contacting my insurance company to verify my benefits. My health insurance policy is a contract between me and my insurance company, and the total bill is my responsibility. Any disputes over payments from my insurance company are my responsibility to resolve with them.

If Alina Tsirelson is out of network with my insurance company, I will be responsible for the full cost of services at the time they are rendered. A superbill can be provided for me to submit to my insurance company for potential reimbursement.

I understand that sessions may be conducted via phone or secure video platform. I acknowledge that while every precaution will be taken to protect my privacy during electronic sessions, complete security cannot be guaranteed, and I agree to use private devices and secure networks when participating in telehealth sessions.

I understand that my insurance company may require this practice to provide clinical information, including my diagnosis and treatment summaries, as a condition of processing claims. By signing below, I authorize the release of such information to my insurance carrier as needed for billing purposes.

ALINA TSIRELSON | LPC  
THERAPY FOR INDIVIDUALS, COUPLES & FAMILY

My signature below confirms that I have read, understand, and agree to all of the above.

_____ Signature of client (or person acting for client)	_____ Date
_____ Printed name	_____ Date of birth
_____ Relationship to client (if signing on behalf of client)	_____ Date

I, the provider, have discussed the information above with the client (and/or their parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to provide informed consent.

_____ Signature of therapist	_____ Date
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- Copy accepted by client       Copy kept by therapist

*This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.*