Consent for Counseling Services

Office Policies & General Information Agreement for Therapy Sessions

This form provides, you the client, with information that is additional to that detailed in the Notice of Privacy Practices and it is subject to HIPPA preemptive analysis. Further information is detailed in the HIPPA Notice of Privacy Practices posted online at pillarsofhopecounseling.com

Please print your name and sign at the X.

Name____

I request Angelie Karabatsos provide professional counseling, talk therapy, services for myself and/or my significant other.

Name of Partner ____

I understand that Mental Health Services of Professional Counseling (talk therapy) is provided to me/us at a cost of $65.00-$85.00 per session for individuals and $90.00- $115.00 per session for couples. $125.00 /session for Family.

I agree payment of services is due at the time of services, even if I am seeking reimbursement from my insurance company. I understand there is no guarantee of coverage or reimbursement for fees.

I understand it is my responsibility to contact my therapist, 24 hours in advance, if I am unable to keep my appointment time to avoid paying full charges for missed appointments.

I understand that my therapist will not be available for 24 hour crisis intervention or emergencies and I have been informed where to call if I have any emergency; Washington County Crisis Line (503) 291-9111, the National Suicide Prevention LifeLine (800) 273-8255, or 911.

I acknowledge that I have received a copy of Angelie Karabatsos' Professional Disclosure Statement and have been directed to pillarsofhopecounseling.com for a copy of HIPPA Notice of Privacy Practices. I will review these documents and understand I may discuss questions with my therapist anytime during my treatment.

I understand that email, text, and social media are not confidential forms of communication. I give permission to be contacted by the following forms of communication: Phone ☐ Email ☐ Text ☐
I may request a change at any time by submitting a written request of change to Angelie Karabatsos.

If there has been no appointments within 90-days the relationship will be terminated. Clients may resume counseling at anytime.

I have read and understand the above information. I consent to therapy in full agreement with the terms stated above with the understanding that my therapist and I will clarify goals and objectives at any time.

X____ ________________________
Signature of Client Date

X____ ________________________
Signature of Client Date

I, **Angelie Karabatsos, LPC, NCC** have discussed the issues above with the client. My observations of the individual or couple's behavior and responses give me no reason to believe that this individual or couple is not fully competent to give informed and willing consent.

Therapist Signature Date

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