Stacey A. Bailey PLLC
221 N East Ave, Suite 205
Fayetteville, AR 72701
479-879-5143

# AGREEMENT AND CONSENT TO TREATMENT

I hereby authorize Stacey A. Bailey to provide mental health counseling services. I understand that I will be given the opportunity to discuss the development of treatment plans.

I understand that all conversations with my therapist will be kept confidential per HIPPA and that no information will be released without my written consent. If I am a minor, I am aware that my parents may have access to information regarding my counseling and may authorize release of information on my behalf without my consent. I understand that any information and/or records relating to treatment are bound by the standards of confidentiality set forth by the American Counseling Association. I consent to the following limits of confidentiality: (A) in cases of imminent danger to self or others, (B) client information may be shared with one William F. Symes, M.DIV., LPC, Licensed Clinical Supervisor, for the purposes of enhancing client care, (C) client information may be shared with support staff, insurance companies or any parties related to billing of services.

**I understand that I will be charged a $35.00 fee for a missed appointment**. I understand the policy of giving 24 hours' notice for cancelling an appointment. I assume financial responsibility for all charges that may be incurred for treatment rendered, whether or not my insurance carrier pays for such services.

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Billing information from Stacey Bailey's office:

Payment is due at the time of services. Any unpaid client balance larger than $100 will need to be paid prior to rescheduling an appointment.

We are happy to help clients receive maximum allowable insurance benefits for those that choose to use insurance. The filing of insurance claims is a courtesy that we have always extended and we will make our best effort to collect from your insurance company, however all charges are the client's responsibility if, despite our best efforts to collect from insurance, we are not successful.

Please check the appropriate area:

☐ I choose to use insurance and my copay will be _____ per session.

☐ I do not choose to use insurance and my fee will be _____ per session.

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***(Please fill out the following:)***

*In being notified by support staff of appointment times and any other important information, I prefer to be:*

☐ *Texted at*_____ ☐ *phoned at* _____

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Your cooperation with these policies is greatly appreciated!

I have read and understand the above policies.

(*Printed name of client*)_____ (Date) _____

(*Signature – parent or guardian signature if client is a minor*) _____