STEPHEN PRAVEL, PhD

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CONSENT TO TREATMENT

I hereby certify that I understand:

That the services and treatments **I/my child/my ward** will receive from me at this facility is based on current practice in the field of mental health (psychology, psychiatric social work). My license is available for inspection.

The goals of therapy are for improved mental health with specific goals to be mutually established between myself and you, your child, or your ward.

That all records are confidential and can be released only as allowed by law under the statutes of the State of Michigan and the Health Insurance Portability and Accountability Act (HIPAA). If my treatment is paid for by an insurance company, either partially or fully, I understand that the company has the right to examine my records, and that records may be reviewed by an agency involved in the accreditation process of my practice.

SERVICE AND FEE AGREEMENT

Initial Evaluation - $250
Subsequent Sessions - $200
No-show or Late cancel - $150
**late cancel is cancellation with less than 24 hour notice*
**all fees apply unless prior arrangement has been made*

Payment is expected at time of service unless agreed upon otherwise. Failure to remit payment for services rendered within 90 days of billing will result in sending your account to a credit collection bureau and could result in negative scoring on your credit report.

The agreed upon fee for services rendered is: As above: Yes _____ No _____

Other: (*specify*): _____

(unless otherwise indicated, "services rendered" is defined as continuing psychotherapy/psychological counseling

I have read, understand and agree to the above **Consent to Treatment and Service and Fee Agreement**.

_____
Patient Name *(printed)*

_____ _____
Signature of Patient *(or Parent/Guardian)*. Date

_____ _____
Witness - Stephen Pravel, PhD Date