Serenity Counseling Services Hawaii LLC
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CLIENT CONSENT TO TREATMENT

___ I have read the informed consent packet and had sufficient time to consider it carefully and I know I can ask questions about treatment or information at any time. I know all information disclosed or in written records is confidential, except where required by law. I know my provider is legally required to contact the proper authorities if they believe I will harm myself or others, including children being abused or witnessing abuse.

___ I am over age 14 and consent to treatment or treatment of my child and know that children must have **both** parents signature on this form if the child parents have joint custody or are in an ongoing custody arrangement.

___ I understand the risk of using online/telephonic methods to discuss treatment, and do not hold Serenity or its providers responsible for the security of any information that is sent by me or to me electronically or via email.

___ I consent to the use of a diagnosis, and the release of information needed to complete the billing and or collections process. I agree to pay any and all fees my insurance doesn't cover, including co-pays at the start of my session or when notified by Serenity. I also agree to pay a 20% add on fee should any debt go to collections.

___ I agree to pay a fee of $20.00 for speaking with my therapist outside appointments for every 15 minutes.

___ If I miss an appointment or cancel without 24hr notice, I will pay a **$100 NO SHOW/Cancellation Fee**.

___ I understand if I fail to show/call or reschedule within 7 days of my last appointment, my therapy case will be closed. If on a repeating schedule, and I do not show up for a scheduled SECOND session thereafter, I will be charged and agree to pay an extra $100.00 NO SHOW/Cancellation Fee prior to my case being closed.

___ Serenity therapists default policy is to **NOT keep secrets** from spouses seeking relationship help and I will not hold my provider or Serenity liable for any information that is revealed in individual or in joint sessions.

___ I agree not to disparage Serenity or its providers on any platform or electronic media as this could do irreparable harm to providers at Serenity not involved in anyway with my care.

___ I agree to allow counseling related students to join in my session and understand that they too are to keep my information confidential and that I can deny a student/s into my session at any time for any reason.

___ I agree that my provider may consult with or refer to other professionals and exchange information within Serenity as part of a treatment team to maximize my treatment for individual, couples or family therapy.

___ I agree that I am ultimately responsible for my appointments and may or may not get a phone call/text reminder prior to my appointment. And I agree if I am not called back to make an appointment within 24hrs of my last attempted contact I WILL email Serenity at Info@scshawaii.net to arrange the appointment electronically.

___ I know I can end treatment at any time or ask for a different provider and that I can refuse any requests or suggestions made by Serenity or any other professional.

___ I will pay a fee for any documents I request my provider to fill out or provide to me. I will speak to each provider/s directly when requesting any documents and understand processing my request may take up to 72hrs.

___ **Life coaching** is a cash pay service. Records of my visits will be kept. No medical records or Dx are given.

___ **Active Duty Military Service Members**: I know my diagnosis may not be honored by the military and that if my condition interferes with my duties/mission and I did not disclose this to my command I may face UMCJ action and release my provider to inform my command if they feel I could place myself or my duties at jeopardy.

NOTE: Serenity Counseling Services, LLC only provides admin support for providers as independent contractors who are working in their own Private Practice. **Please, only make appointments with the receptionist/front office staff or call center.** Your signature below is evidence and expressed consent that you have read, understand and agree to the Informed Consent Policy, HIPAA Privacy Practices Policy, the Notice of Privacy Practices Policy, and that you agree to all terms herein and on this form and that information you provided is true and accurate to your memory.

_____ ==> _____

Print Name of Primary Patient Signature of Primary Patient

_____ ==> _____

Print Name of Second Patient or Parent/Legal Guardian Signature of Second Patient, Parent/Legal Guardian

_____

Date