Kim D. Kemske, Psy.D., LP
24120 Meadowbrook Rd, Suite 202, Novi, MI 48375

CONSENT TO TREATMENT

I, the undersigned, certify that I understand that the services I will receive from my therapist have been explained to my satisfaction. The risks, benefits and alternatives to these services have also been explained. I also understand that the result of these services cannot be guaranteed or warranted. An initial plan or approach has been developed jointly by my therapist, Dr. Kim Kemske, by my family members, if appropriate, and by me. I agree with this plan or approach and I voluntarily consent to treatment.

RECIPIENT RIGHTS: The information I give to my counselor is confidential. She will not release information to anyone, including family members, without my written consent. The only exception to my right to complete confidentiality is by court order, or in those situations that are life threatening, or which involve child abuse or neglect, or which involve certain cases of the abuse of a vulnerable adult, or which involve the commission or threat of a crime on the counseling program premises, or against oneself or against a third party. No client records are kept at a central location. Your therapist is the only one who may keep your information on file. No electronic billing or information is ever shared without your express written consent.

FOLLOW-UP: I agree to discuss openly my wish to end therapy, for any reason, at least one session prior to my last session. This is requested to help me to acknowledge and summarize what I have accomplished and to provide an orderly ending to the relationship that is developed through the course of therapy. Any need for referrals is also determined at or before the final session. Although this is not a requirement, it is strongly recommended.

I hereby consent to allow my therapist to follow-up for purposes of determining the outcome of the treatment services applied, as long as my right to confidentiality of patient information is protected.

Note: You are responsible for any deductible and/or copay at this time.
FEE AGREEMENT: I agree to pay $195/180/120 per counseling session (charges vary according to session type and length). I understand that this amount is payable at time services are rendered unless otherwise negotiated with my therapist. I understand that if I cancel an appointment with less than 24-hour notice (48 hours for Monday appointments) or if I fail to appear for a scheduled appointment, I will be charged $120 for the session. I further understand that if I am late for my scheduled appointment, I may not receive the full session time. If my therapist starts the session late, that time will be made up to me.
[NOTE: Emergencies will be excused. Any other excused absences are to be pre-arranged with your therapist with a 24- hour cancellation notice in order to avoid unnecessary charges. The hour is set aside for you and we ask your courtesy in giving us time to schedule another person if you will not be available for the scheduled hour. Charges for unexcused absences are not paid for by insurance companies or other third party payers and must be paid by the client.]

All checks are to be made payable to Dr. Kim Kemske. Receipts will be provided upon request. I hereby give permission to submit all necessary billing information as requested by third party payers, and understand that, with or without third party payment, I am ultimately responsible for all charges incurred. I have had the opportunity to ask questions. I understand and agree to the statements and conditions specified herein.

_____		_____	
Client Signature	Date	Client Signature	Date
_____		_____	
Parent/Guardian/Family Signature	Date	Therapist Signature	Date

[If a client is a minor, his/her parents or guardian must consent to treatment of that child and may be asked to be involved in the therapy at the discretion of the therapist.]