INFORMED CONSENT
Komraus Compassionate Counseling P.L.L.C.

Rosewood Office Plaza
47100 Schoenherr Road Suite B
Shelby Twp, MI 48315
586-543-6655

Client Services

Komraus Compassionate Counseling P.L.L.C provides:

Therapeutic counseling services for individual adults and adolescents 15 years of age and older
Therapeutic counseling services for couples
Therapeutic counseling for substance abuse services for individual adults and adolescents 15 years if age and older

Office Hours

Monday-Thursday	10:00 AM to 6:00 PM
Friday, Saturday and Sunday	No office hours

Clinic Policies

Fees: My fee is based on a 45 to 55 minute session for individuals or couples.

Payment for services is expected at the full rate of $150 .00 for the initial intake session, $160.00 for the initial couple, marital session, and 125.00- per individual session and $140.00 for couple, marital session thereafter.

If you are unable to pay the full charge, the portion for which you are responsible will be based on your family income. Proof of income is **required** in order to receive a reduced fee.

All session fees are collected prior to the start of each session.

I accept cash or a personal check. A $25.00 fee will be billed for all returned checks and checks will not be accepted in the future.

Cancellation:

If you do not cancel your appointment at least **24-hours in advance**, you will be charged a no show fee which will be equal to the cost of a full fee for session in

the amount of $125.00-$140.00 whichever is greater per missed counseling appointment.

These fees must be paid at your next scheduled appointment.

Compliance

Failure to show for two (2) consecutive appointments will result in termination of treatment with no notification, unless there are extenuating circumstances. Additionally, frequent cancellations without proper notice, no-shows or no face-to face contact with me within a thirty (30) day time frame may lead to termination of treatment for noncompliance.

Recipient Rights-Consent to Treatment-Client Confidentiality

I understand that I have rights as a recipient of services, including confidentiality of my records, and that I can get more information about my rights from the Recipient Rights Advisor.

I consent to mental health treatment or substance abuse treatment as recommended by the therapist. I understand that I will participate in the development of my treatment plan and that I am free to withdraw my consent and discontinue treatment at any time.

Federal law and regulations protect the confidentiality of Protected Health Information, and/or alcohol and substance abuse patient records maintained by this company. This company may not say to a person outside the agency that a patient attends counseling or disclosure any information identifying an individual as a patient or as an alcohol or substance abuser **UNLESS:**

1. **The patient consents in writing**
2. **The disclosure is allowed by a Court order, or**
3. **The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit or therapy evaluation.**

I have read this agreement. I had the opportunity to ask questions which have been answered to my satisfaction. I understand and agree to the conditions specified herein.

Client's Name printed Date

Client's signature (or parent's signature if client is a minor) Date

Clinicians Signature and Credentials Date.