MGR Wellness Counseling, LLC

51 Depot Street, Watertown CT 06795

Phone: 860-880-0776

Consent for Treatment – Outpatient Services Contract

Welcome to MGR Wellness Counseling. This document contains important information about our professional services and business policies. Please read it carefully and feel free to ask any questions you might have. When you (or your authorized representative such as a parent or guardian) sign this document, it will represent an agreement between us.

Professional Services

As licensed professional counselors (LPC), We are trained to see patients across the age spectrum. Services include assessments, diagnosis, on- going brief supportive and behavioral therapy as part of individual therapy sessions on a case by case basis. Our initial appointment will be for consultation only. Following this appointment, if mutually agreed upon treatment goals are identified, then we will continue working together. Children cannot be seen without proper consultation with all providers involved. Therefore, with your consent, we will be in contact with the child's therapist, pediatrician, school, or other providers as treatment necessitates. The success, length, and course of treatment are affected by many things, including the severity of the problem and the motivation of the patient, among other factors. The best outcome is achieved through collaboration between the patient and provider. We do not provide forensic services such as custody evaluations, ability to stand trial, etc. If you are in the process of a divorce or custody dispute, it must be disclosed immediately.

Confidentiality

Communication between a patient and his/her mental health provider is held in confidence and will not be revealed to an outside agency without written consent unless specifically required by law (for example: child abuse, imminent threat of danger to yourself or others, court order, etc.) Information released to insurance companies for reimbursement for services is released only with your authorization. If the patient is under 18 years of age, the law may give parents/legal guardians the right to access your records. It is our policy to request an agreement from parents that they will relinquish this right so that patients under 18 (especially teenagers) may have privacy in their sessions. An exception would be if we believe there is a risk of imminent danger to oneself or others.

Communication

We can be reached by email at MGRwellnesscounseling@gmail.com or by calling **860-880-0776** and leaving a message. **Routine calls are usually returned within 24-48 hours during the work week. For true medical and psychiatric emergencies please call 911 or go to your nearest emergency room**.

Professional Fees and Payment

Your insurance may or may not cover the cost of your office visits, tests or certain procedure codes. Non-covered and out-of-network services are the financial responsibility of the insured. We participate with some insurance companies, but not all. While you will be provided with the best information available, it is your responsibility to check with your insurance company prior to the visit to verify coverage and benefits.

Discontinuation of Treatment

Typically, the decision to terminate treatment is made through mutual and thoughtful discussion involving the provider and patient. In the event that you discontinue treatment without notifying my office, we will assume that your therapeutic relationship with George J. Rehkamp, LPC or Marisa Mastrianno, LPC terminated 90 days after your last visit (unless you have an appointment scheduled for a future date) beyond which I carry no further responsibility for your care.

Acknowledgement of Treatment

My electronic signature (or that of an authorized representative such as a parent or guardian) below acknowledges that I have read, understand, and accept this policy and consent for treatment for myself (or my minor child) and accept responsibility for all fees incurred. If the patient is a minor child, I acknowledge that I have the legal authority to consent for treatment of this child. I understand that I have the right to withdraw this authorization at any time.

Patient Name: _____

Parent/Guardian Signature:_____

Date:_____