Victoria Mental Health Services Ltd.
Greg Walsh, LICSW
1600 Arboretum Blvd., Ste. # 211
Victoria, MN 55386
Phone: 952-443-3970

Consent for Treatment:

By signing below, you are giving informed consent for treatment and you are also stating that you have received, read and understood the Client Information and Office Policy Statement and agree to its terms unless otherwise stated in writing.

I, (client **or** parent/guardian of minor) please print _____ give my consent for counseling with Victoria Mental Health Services and its staff to include evaluation, psychological counseling, and involvement in the treatment planning process. I do understand that I may decline at any time specific treatment recommendations.

Notice of Privacy Practices and Patient Bill of Rights

In compliance with HIPAA legislation, I have been provided an opportunity to review Victoria Mental Health Services, Ltd. Privacy Practices & the Patient Bill of Rights. Signing below indicates that I have read, understand HIPAA Limits of Confidentiality and agree to its terms, unless otherwise noted in writing.

Payment Contract for Services: Name(s) of client(s) receiving services: _____

Person responsible for payment (if different) _____

Federal Truth in Lending Disclosure Statement

Clients with insurance coverage: Some insurance companies have incorporated your Social Security number as part of your ID number. Please check your card & see if this is required and fill in your full ID number here.

Insurance Carrier: _____ Full ID #_____Group/Acct.#_____

Insurance: We suggest that you confirm your benefits with your insurance company. I acknowledge that I am responsible for providing Victoria Mental Health Services, Ltd. with insurance information that is complete and current. I give my consent for the release of clinical/other information necessary to an insurance company or 3rd party medical benefits to Victoria Mental Health Services, Ltd. for services rendered for the purposes of payment as indicated by MN law.

Clients without insurance coverage: I (we) agree to pay Victoria Mental Health Services, Ltd. a rate of $_____ per clinical unit (defined as 50-53 minutes for assessment, individual, family & joint sessions).

Financial policy for all clients: When I receive services from Victoria Mental Health Services, I take on a personal obligation and responsibility for my account. I agree to that all payments, co-payments, and deductibles are due at the time of service as documented in the Explanation of Benefits (EOB) provided by my insurance company.

Emails & texting: I understand that Victoria Mental Health Services email as well as texting is not secure. Therefore, if I elect to use either of these options to communicate with Victoria Mental Health Services it is voluntary and at my own risk. I also understand that should I elect to email or text Victoria Mental Health Services, it is in my best interest to refrain from including personal or private information. **Please check below **i**f you give your consent – thank you.

( ) I consent to send/receive text messages ( ) I consent to send/receive email.

By consenting to treatment and signing this form, I am agreeing to these policies and conditions of this form including the Federal Truth in Lending Disclosure Statement for Professional Services.

Client Signature (or parent/guardian if minor) _____ Date: _____/_____/_____

Spouse's Signature (for marital/couple's counseling) _____ Date: _____/_____/_____

Name of minor being treated (if applicable) _____