**Eva Hudlicka, LICSW, MSW, PhD – Psychotherapy**

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**CONSENTS FORM**

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Client name Date of Birth

The authorizations and consents listed below are required before we can begin treatment. Please be sure to understand each consent or authorization, and do not hesitate to ask for any clarifications.

\_\_\_\_\_\_ CONSENT TO TREATMENT: I consent to receive psychotherapy

Initials from Eva Hudlicka, LICSW. I understand that this consent is entirely  
 voluntary, that I do not have to accept any treatment option offered to me,   
 and that I may withdraw my consent at any time for any reason.

\_\_\_\_\_\_ THERAPIST-CLIENT SERVICE AGREEMENT: I have read,

Initials understood and agree to the terms included in Eva Hudlicka’s  
 Therapist-Client Service Agreement.

\_\_\_\_\_\_ CONFIDENTIALITY: I understand the confidentiality policies, as

Initials well as its limitations, as described in the Therapist-Client  
 Service Agreement and as explained verbally by Eva Hudlicka, LICSW.

\_\_\_\_\_\_ LENGTH AND DURATION OF TREATMENT: I understand that

Initials standard individual therapy sessions are 50 minutes long (unless  
 otherwise specified by my insurance policy). I understand that the  
 duration of treatment depends on many factors, and that short-term

treatment typically lasts between several weeks to several months.

\_\_\_\_\_\_ DESCRIPTION OF PRIVACY POLICIES: I have read and understand the

Initials Notice of Privacy Policies.

\_\_\_\_\_\_ CANCELLATION AND MISSED APPOINTMENTS POLICY: If I

Initials miss an appointment or provide fewer than 24 hour notice, I agree  
 that I will automatically be charged a cancellation fee of $45.00. I  
 understand that my insurance does not cover this expense and  
 and that a payment will be due during the next session.

\_\_\_\_\_\_ EMAIL or TEXTING CONTACT BETWEEN THERAPIST & CLIENT:

Initials If I decide to communicate via email or text, I understand that I am   
 doing so with the full understanding that this communication may not

be secure, that email or text may get lost or delayed, and that  
 sending an email or a text message is no guarantee of its receipt.

\_\_\_\_\_\_ FINANCIAL OBLIGATION: I agree to pay for all services provided,

Initials regardless of whether there is insurance coverage. If I am using   
 insurance to pay for services, I agree to be familiar with the specific   
 terms and limits of my insurance coverage. Unless a payment plan   
 has been arranged at the beginning of treatment, I agree to pay any

self-pay fees, insurance co-payments, and/or co-insurance and  
 deductibles by the end of each session.

\_\_\_\_\_\_ ASSIGNMENT OF INSURANCE BENEFITS AND BILLING   
 Initials AUTHORIZATION: I authorize the payment of my insurance   
 benefits directly to Eva Hudlicka, LICSW, for psychotherapy  
 services provided. I also authorize Eva Hudlicka, LICSW to bill  
 my insurance company for her services and to release my health  
 information necessary to process insurance claims associated with  
 my psychotherapy.

\_\_\_\_\_\_ PRIMARY CARE PHYSICIAN: Please check only ONE of the   
 Initials following:

☐ You are authorized to contact my primary care physician   
 whose name and address are shown below to discuss the   
 treatment that I am receiving while under your care and  
 to obtain information concerning my medical diagnosis  
 end treatment. A separate Release of Information would be  
 required.

☐ You are NOT authorized to contact my primary care physician   
 whose name and address are shown below to discuss the   
 treatment that I am receiving while under your care and  
 to obtain information concerning my medical diagnosis  
 end treatment. I am providing the name/address of my  
 primary care physician only for your records.

ACKNOWLEDGMENT: My initials above and my signature below acknowledge the terms and conditions herein.

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Signature of Client or Guardian Date   
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