**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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