2498 Dayton-Xenia Rd.
Beavercreek, Ohio 45434
Office (937) 427-1919
Fax (937) 427-1949

Therapy Connections, LLC

Consent for Services

Name of Client: _____ D.O.B._____

Address: _____
Street or PO Box City State Zip

Consent to Treat: I hereby grant my permission for the above named client to receive treatment services at Therapy Connections as they have been outlined to me. By signing the following items, I acknowledge the policy of Therapy Connections and my responsibilities at stated below.

Initial: _____ Date: _____

Financial Responsibility: I understand that I am ultimately responsible for my therapy charges, and I agree to pay my deductible, my co-insurance or co-payment, and any charges not reimbursed by my insurance carrier. I understand that some insurance companies require medical or administrative pre-authorization for treatment, or have reimbursement limits on therapy treatment. I understand I am responsible for knowing and meeting the requirements of my insurance plan. I am aware that there is a $25.00 processing fee for any returned check(s) and that this fee must be paid before any future appointments will be scheduled.

Initial: _____ Date: _____

Cancellations/Make Ups: I understand that if I must cancel a session, a 24 hour notice is required. I understand that failure to notify Therapy Connections of cancellation may result in discharge from the program. I also understand that an attempt will be made to reschedule any therapy session. We are unable to hold a time slot for more than two consecutive weeks.

Initial: _____ Date: _____

Privacy Policy: I have been given the opportunity to ask questions about the Privacy Policy of Therapy Connections. A copy of the policy is available upon request.

Initial: _____ Date: _____

Consent for Photo or Video Image: I grant to Therapy Connections, its representatives and employees the right to take photographs or video images of me and/or my child. I authorize Therapy Connections to copyright, use and publish the same in print and/or electronically. I agree that Therapy Connections may use such photographs of me with or without my name and for an lawful purpose, including for example such purposed as but not limited to publicity, newsletters, illustrations, advertising, video and web content.

Initial: _____ Date: _____

The undersigned also certifies that he/she is the client or is the duly authorized client guardian and can execute the above and accept its terms on behalf of the client.

Initial: _____ Date: _____