Antonietta Corvasce, LLC
2940 Chain Bridge Road, NW
Washington, DC 20016
202-249-8976

Consent to Treatment

Thank you for choosing to work with me (Antonietta Corvasce, LPC). I ________________ understand that the psychotherapeutic treatment rendered to me is conducted by Antonietta Corvasce, a licensed professional counselor in the District of Columbia, and that the policies below have been explained to me in a manner I understand. Federal and State laws regulate privacy within the therapy relationship. The following guidelines govern when private health information can be released without your consent, and when your consent is needed. This form is intended to inform you of my policies, State and Federal Laws and your rights. If you have any questions or concerns, please feel free to ask and I will do my best to give you all the information needed.

Confidentiality

Your verbal communication and clinical records are strictly confidential except for:
a) information shared with your insurance company to obtain insurance coverage. This information is limited to: dates of service; session start and stop times; type of therapy; and summary of diagnosis, functional status, treatment plan, symptoms, prognosis, and progress to date. Any insurance request for personal health information not listed above will require a separate written and signed authorization from you; b) information pertaining to physical and/or sexual abuse of a child or an elderly person; then, I am required to report this to the Department of Children and Family Services; c) you are under the age of 16 and have been sexually or physically abused, raped, or the victim of another crime; d) where you sign a release of information to have specific information shared; e) if you provide information that informs me that you are in danger of harming yourself or others; e) for case supervision or consultation and f) or when required by law.

Emergency Policy

In case of an emergency for which the client or their guardian feels immediate attention is necessary and I am unable to return your call, the client or guardian understands that they are to contact the emergency number in the community (911) for those services or go to the nearest emergency room.

Sessions and Payment

Individual therapy sessions are typically 50 minutes. Couples therapy sessions are typically 60 minutes. Payment is expected at the time of service. Payment can be made by cash, check or credit card. As a Licensed Professional Counselor, my professional services qualify for full or partial reimbursement from most insurance companies. I do not participate with any insurance plans as a participating provider. I do participate as an out-of-network provider for plans that have out of plan benefits. You will be provided with a billing statement at the end of each visit, which will include dates of service, charges, payment and appropriate codes required by insurance companies.

Cancellations
I have a 48-hour cancellation policy. In the event of a cancellation less than 48 hours before your appointment, you will be charged for the session.

Notice of Privacy Practices and Client Rights
I/We have read and received a copy of the Notice of Privacy Practices and Client Rights document.

Signture(s)____________________________ Date:________________

Communication between therapist and clients
I can be notified via regular mail for billing purposes: Yes/No

My therapist can leave messages on the telephone number(s) I have provided: Yes/No
Telephone #____________________

My therapist has my permission to email me at the address below:

Email:__________________

Thank you for taking the time to read the Informed Consent. If you have any questions or concerns now or at any point during our working relationship, please feel free to let me know. Please sign below to indicate that you have read this and have had a chance to ask any questions.

I have read this informed consent, discussed it with my therapist, understand the information contained and agree to participate in treatment under the conditions described.

___________________________	___________________________
Print name of client	Print name of therapist
___________________________	___________________________
Signature of client	Signature of therapist
___________________________	___________________________
Date	Date