JUDITH L. THURSWELL, Psy.D., LP, CAAC

5777 WEST MAPLE RD. SUITE 177

WEST BLOOMFIELD, MI. 48322

PHONE: (248) 613-4443

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# CONSENT TO SERVICES

I. TREATMENT:

I _____, DOB:_____ on this day of _____ acknowledge that I am voluntarily seeking services from the Practice of Dr. Judith Thurswell, clinical psychologist. I understand, that per agreement with Dr. Thurswell, the meetings will be either in-person, or via Telehealth for Mental Health platform by phone or video conferencing. I am knowledgeable about the purpose of this relationship and of the services offered and I am aware of any risks, consequences, and of benefits related to the services offered.

I understand that the successful completion of services is determined when Dr. Thurswell and myself, agree that the goals of treatment have been substantially attained. However, I also understand that I am free to discontinue service by my own, at any time and that Dr. Thurswell reserves the right to discontinue working with me as well, for non-compliance with recommendations or for threatening this Practice's personnel or property. Should this occur, Dr. Thurswell will make a good faith effort to make an appropriate referral to another therapist.

II. PRIVACY:

I understand that under the Health Insurance Portability and Accountability Act of 1996, (HIPAA) I have certain rights to privacy regarding my protected personal and Health Care information. I understand that this information can and will be used by Dr. Thurswell to:

- Conduct, plan and direct my treatment and follow-up among multiple health care providers who may be involved in the treatment directly or indirectly.
- Obtain private pay and/or payment from third party payers.

Additionally, I have been given a copy of the *Notice of Privacy Practices* containing a more complete and detailed description of the uses and disclosures of my personal health information. I have been given the right to review the *Notice of Privacy Practices* prior to signing this consent. I understand that I may request from Dr. Thurswell in writing, to restrict how my private information is to be disclosed or used in the process of the therapeutic relationship. I understand that Dr. Thurswell may not agree to my requested restrictions, however, if she does consent, she is then bound by such restrictions.

III. PAYMENT:

I agree to be responsible for the timely payment of the agreed charges, which are due at the end of each session (by cash, check or credit card) unless a different written agreement has been made with Dr. Thurswell. I am aware that if I choose to use health insurance for Dr. Thurswell's services, I am responsible for any co-pays, deductibles or other fees that are not covered by my insurance carrier. I agree to the 24 hour advanced cancellation of appointment notice and understand that a full session rate charge is made for cancellations less than 24-hour notice. Unforeseen emergencies will always be considered.

III. REVOCATION:

It is my understanding that I may revoke this agreement in writing at any time, except to the extent that Dr. Thurswell has already taken action relying on this consent.

CLIENT (S)' NAME(S): _____

SIGNATURE(S)/ DATE: _____

PARENT(S)/ LEGAL GUARDIAN/ DATE:_____