Date Received

INFORMED CONSENT / THERAPEUTIC AGREEMENT

Client Name: ____

As our clients, it is important you are fully informed about the services you will receive. Your signature on the following page indicates you have received, read, and understand your individual rights and responsibilities as it relates to the practices and policies of Axiom Counseling & Therapy Services, LLC and The Attention & Learning Center.

- I understand that during and after the course of treatment, communications with my therapist will remain private and confidential as mandated by Kansas Law (K.S.A. 65-6410). However, circumstances may require my therapist to share or report information obtained during the therapeutic process. Those circumstances are:
    - The client is thought to be a danger to themselves or to others
    - The therapist is served with a court order
    - There is reason to suspect abuse or neglect of a child, disabled adult, or elderly person

- I give my therapist permission to consult with other mental health professionals within Axiom Counseling & Therapy Services, LLC and The Attention & Learning Center for the benefit of my counseling. I understand all other requested communication will require my written consent.

- I understand if I choose to utilize third party payments, my insurance company may require information prior to service. Any information given to a third-party payer will be strictly for the benefit of claims submissions.

- I understand my therapist is professionally bound by a code of ethics set forth by the American Association of Marriage and Family Therapists and I can request a copy at any time.

- I understand I have the right to an explanation of procedures and therapy styles, discussion of therapy in progress, and a summary of test results conducted by my therapist.

- I understand I have the right to discontinue services at any time.

BENEFITS AND RISKS

Challenges in life may lead to anxiety, depression, isolation, and/or other health related problems. Counseling is a unique experience that promotes emotional growth and healing. Through counseling, you may begin to better understand your emotional needs. Personal insight gives you more confidence in multiple areas which lead to strength and satisfaction in life.

However, counseling can also be difficult and challenging at times. While working to improve the quality of life, discovering triggers that cause emotional distress in life may cause feelings of anger, fear, and frustration. The journey to emotional health is not always easy, but the professionals at Axiom Counseling and Therapy Services, LLC are dedicated to walk with you on your journey with compassion and encouragement. We hope to help you find clarity, healing, and purpose.

FEES AND PAYMENTS

- Individual, couple, and family therapy sessions are billed at $130.00 per clinical hour (56 – 62 minutes). Self-pay clients are given a discount of approximately 23.5% for an out of pocket total session cost of $99.00.
- **All payments – including co-payments – are due at the time of service.** Cash, checks, and all major credit cards are accepted.
- Cancellations must be made at least 24 hours before a scheduled session. Failure to give proper notice or failure to show for a scheduled appointment will result in **$50.00 fee** being applied to your account. **These fees require cash payment and are not eligible for third-party billing.**
- Any legal and/or court related duties requested will be billed at regular session rates. **These services require cash payment and are not eligible for third-party billing.**

CHILDCARE INFORMATION

Axiom Counseling and Therapy Services, LLC does not provide childcare and is not responsible for children left unsupervised in the lobby. Minors must be picked up on time following their appointments. If you must leave your child in the lobby during a session, it is your responsibility to provide appropriate supervision. Children under the age of 10 may not be left without supervision.

UNDERSTANDING / AGREEMENT

I have fully read and accept the disclosed information. By signing, I choose to begin therapy under the guidelines listed.

Client / Authorized Signature: ____

Client / Authorized Signature: ____

Therapist Signature: ____________________________________ Date: ______________