Limits of Confidentiality and protected health information:

Please note: your therapist is a mandated reporter and is required by law to report allegations of harm to self, harm to others, child abuse, elder abuse, and can be ordered by a judge in a court of law to breach confidentiality. It is not the therapist's position to determine if any of the allegations being reported are true, however it is the legal and ethical duty of the therapist to report any of the aforementioned allegations to the appropriate agency.

I understand that all information we discuss in my counseling session today is confidential and that my therapist is to always maintain this confidentiality. However, there are limitations to this law, if I express that I will harm myself or harm others, report child abuse or elder abuse, or if my therapist is mandated by a judge in a court of law to release my information.

As the parent/guardian of a minor client, I understand that I have a right to view the therapy record for the client. However, in order to protect the client/therapist relationship, I agree as the parent/guardian to not access any information pertaining to the client. I understand that my therapist will inform me if there is a concern of the client that will/may be and/or could be of harm to the client or to someone else as described in the limits of confidentiality.

I understand my rights and limits of confidentiality and have had the opportunity to ask questions to my therapist.

Signature of Client/parent/guardian_____Date:_____

Signature of staff completing or reviewing form (including credentials) _____Date:_____

THERAPY INSTITUTE OF MICHIGAN LLC

Helping You Build A Life Worth Living

Welcome to the Therapy Institute of Michigan LLC

Consent to Treatment

We are pleased that you chose the Therapy Institute of Michigan, LLC (TIM Center) to assist you with building your life worth living goals. As a new client we ask that you complete some necessary forms that will help us with your assessment appointment. Also, take a few minutes to look over the following information. These important points will assist in making your visits here satisfactory. Please initial each item to indicate your understanding.

_____ I understand that office hours are by appointment only and that no one may be available in the office without a prior scheduled appointment with my therapist.

_____ I agree that I am financially responsible for all charges whether or not paid by insurance, for all services on my behalf or my dependents, and that all co-pays or outstanding balances are due at time of services rendered.

_____We will bill your insurance company as a courtesy; however, you are responsible for knowing if today's services are covered and for any outstanding balance or fees not covered by your insurance. Co-Pays, deductibles, and/or Co-Insurance are due at the time of service. Any previous balances must be paid in full prior to next session

_____ If there is a change of insurance; I will need to inform my therapist. Failure to do so may result in being charged private pay fees for the services, which are due at the time of services rendered. I am aware f I have not paid for services received, reach a cash balance of $100.00, and have not made payment arrangements, The TIM Center may discontinue my treatment by instituting a temporary discharge from therapy, until my obligations for payment or payment arrangements have been met. I also understand that if I neglect to take care of any balance, the TIM Center may seek outside collections services to collect the balance, and any additional fees will be assessed to my account.

_____ I consent/do not consent (Circle one) to email communication with my therapist that is restricted to confirming/cancelation of my appointments. My email address is:
_____

_____ I agree to call 24 hours in advance if I need to cancel my appointment. *Failure to give a 24-hour cancelation notice will result in a (sixty dollar) $60.00 no-show fee. Charges for no-show appointments are the client's responsibility*.

_____ All payments, co-payments, deductibles, and co-insurance are due at time of check-in

_____ I am aware that I may terminate my treatment at any time without consequence, but that I will still be responsible for payment for the services I had received.

_____ I am aware that neither this office nor any therapist is responsible for any personal property or valuables I bring into its facilities. I acknowledge that, if I or anyone else for whom I am legally responsible, deliberately causes damage or steals any property of this office, I will be held financially responsible for its replacement.

_____I am aware that the practice of psychotherapy or counseling is not an exact science, so predictions of the effects and effectiveness are neither precise nor guaranteed. I acknowledge that no guarantees have been made to me regarding the results of treatment or procedures provided by the TIM Center LLC.

_____ I acknowledge I have received, read, and understand the HIPAA form.

_____ In the event of the loss of your therapist to death, leaving the practice, etc., your files will be reviewed and handled by one of the licensed owners of the TIM Center. You will be referred to another therapist within the TIM Center LLC or to an outside agency for services. The TIM Center LLC will make every consideration possible to have this done in a timely manner, dependent on remaining therapist availability.

Signature of Client/Parent/Guardian_____Date_____

Signature of Staff (including credentials) _____Date_____

1 Heritage Place, Suite 220
Southgate, MI 48195
734-672-0068
www.tiomllc.com