CONSENT TO RECEIVE TREATMENT

Please read carefully and sign.

1. **I understand that Dr. Mates is a sole practitioner not affiliated with any other Mental Health professionals.**
2. **I understand the business policies of Mates Mental Health Services, PLLC.**
3. **I consent to receive treatment and understand that I am financially responsible for services rendered.**
4. **If insurance is to be billed, I will provide my insurance card and information and will meet any deductible. I will pay any co-payment in full at each visit.**
5. **I will pay the charges for appointments I do not cancel by 5:00 p.m. on the last day before an appointment.**
6. **In case of emergency, when Dr. Mates is not available, you will be referred to the Crisis Line or your nearest emergency room.**

Signed _____ Date _____
(Responsible Party)

Office Manager of Therapist _____

Parental Consent (Must be signed if client is child)

I, _____(your name) do hereby certify that I have legal custody of/am the legal guardian for medical consent purposes of _____ _____(child's name). I give my permission for him/her to receive mental health treatment or evaluation.

_____ _____
Parent/Guardian Witness

_____(Date) _____(Date)

APPOINTMENTS:

Initial Interview – 0 - 60 minute session

Family Therapy – 38 - 52 minute session

Psychotherapy – 38 - 52 minute session

Psychotherapy/follow-up - 20-30 minute session

According to CPT IV, the following procedures are billable contracts and treated as such: TELEPHONE CONSULTATIONS, COLLATERAL CONTACTS WITH RELEVANT AGENCIES, and WRITTEN REPORTS CONCERNING DIAGNOSIS AND TREATMENT OF A PATIENT. All of the above are billed according to time involved. Charges not covered by third party insurers are the responsibility of the patient.