LEE JACOBS RIGGS, LPC, LCPC
**P** 773.797.2261 **E** LJACOBSRIGGSLCPC@GMAIL.COM

## Consent for Treatment

I, _____ acknowledge that I have received and understand the counseling agreement between myself and Lee Jacobs Riggs, LPC, LCPC. I consent to receive counseling services from Lee Jacobs Riggs, LPC, LCPC and to adhere to the terms of this agreement during the course of our relationship.

_____

**Client Signature** **Date**

## Sliding Scale Fees

I will pay the agreed upon fee of $_____ per session.

I understand that sliding scale fees are agreed upon for four months and will be revisited four months after initiating counseling and once each calendar year. If my financial situation changes and I am able to pay more than the agreed upon sliding scale fee, I agreed to share this information with Lee Jacobs Riggs, LPC, LCPC so that we may adjust my fee accordingly.

_____

**Client Signature** **Date**

## Insurance

I consent for Lee Jacobs Riggs, LPC, LCPC to release information to my insurance_____ for the purpose of collecting insurance payment for services rendered. Information shared may include, but is not limited to, dates and times of sessions, diagnosis, and treatment plan.

I will pay the copay/coinsurance of $_____ per session. I understand that I am responsible for the remainder of the full fee if insurance does not cover the total cost, unless we have made other arrangements or prohibited by the insurance company.

_____

**Client Signature** **Date**

## Acknowledgement of Privacy Practices

I acknowledge that I have received and understand the Notice of Privacy Practices.

_____

**Client Signature** **Date**

_____

**Counselor Signature** **Date**