

## Consent for Treatment & Agreement for Working Relationship

*Please read and initial next to each statement, indicating your understanding and agreement, and sign below. You are welcome to ask for clarification on anything you need to.*

\_\_\_\_\_ I consent to be involved in counseling, psychotherapy, behavioral health treatment, or personal growth work with Lisa Fladager, MCAT, LMHC, R-DMT, CMA.

\_\_\_\_\_ I have been given information about her training, credentials, and methods of working and understand that I have an ongoing opportunity and permission to ask questions or clarify anything I have questions about.

\_\_\_\_\_ I agree to pay the fee of 100 dollars per 60 minute hour, due at the time of service, unless another payment arrangement has been made.

\_\_\_\_\_ I understand that I am required to provide 24 hours notice of cancellation or I will be responsible for paying the full fee for my missed session.

\_\_\_\_\_ I understand that I am eligible for mental health crisis services 24 hours a day, 365 days a year, by calling the VOA Care Crisis Line at 1-800-584-3578. This service is free to me.

***My signature below indicates that I understand and agree to the above, and that I take responsibility for reading the following information, which will be provided to me at our first session:***

*“Clinician Disclosure Statement”*

*“What to Expect from your Licensed Mental Health Counselor”*

*“HIPPA Disclosure”*

\_\_\_\_\_  
Client signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Clinician signature

\_\_\_\_\_  
Date