Liz Mau, MS, LP
River Woods Counseling Services

Treatment Agreement

Client Rights and Responsibilities:

I affirm that I have have read and understood the Notice of Privacy Practices and Client Rights form (See Notice of privacy Practices and Client Rights form under "helpful forms" section).

Out of Session Contact and Emergencies:

Due to the nature of my practice, I am often not immediately available by telephone or e-mail. If you leave a message during my scheduled business days (Tuesday-Friday), I will try to reach you within 24 hours. If you call on non-scheduled days (Saturday-Monday or vacation days), I will try to reach you within 24 hours upon my return to the office.

If you are experiencing a mental health emergency when you contact me, please state this in your message. If you need immediate support and cannot wait for a return call, please call **911** or go to the nearest emergency room.

Payment Responsibilities:

▪I have read, completed, and signed the Registration Form authorizing Liz Mau, MS, LP to process my claims and receive payment from my insurance company. I understand that my information can be shared for the purposes of claims and utilization review, quality assurance and peer review by the insurance company.

▪I agree to pay all co-payments or co-insurance required by my health plan.

▪If services I received from Liz Mau, MS, LP are not covered by my insurance company, subject to the provision of my insurance contract, if any, I agree to pay for these services myself.

▪I agree to give Liz Mau, MS, LP 24-hour prior notice of any appointment cancellation. I understand that if I do not give this notice, I may be changed a $50.00 Late Cancelation fee for the session I missed. I am aware that insurance companies will not cover this cost. I also understand if I miss multiple appointments, I may be terminated from therapy.

Treatment Authorization:

I request Liz Mau, MS, LP to plan and provide treatment to me (or my minor child) with my participation. I understand that I may withdraw this consent and terminate treatment at any time, for any reason.

_____ _____

Client's Signature Date
(or parent/legal guardian if client is under 18 years old)

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