Counseling Agreement

(Please complete and sign this section)

I hereby certify that I have read and understand the preceding information and I willingly enter into this counseling relationship with Betty Heil, M.S.W., L.I.S.W. I understand that I am personally financially responsible for all charges not covered by insurance and it is my obligation to pay for counseling services provided at the rate of $ _____ per hour, and that full payment is due at the conclusion of each session.

If filing with my insurance company, I authorize payment of benefits directly to Betty Heil, M.S.W., L.I.S.W. I also authorize Betty Heil to contact my insurance company if any additional information about my coverage is needed, and to release all diagnostic and treatment information essential to complete my claim. My signature below acts as a signature on file, authorizing the release of insurance payments.

_____ _____

Signature of Client __ or Parent/Guardian __ (check one) Date

Address_____ City_____ State_____ Zip_____

Date of Birth_____ Home Phone _____ Work phone_____

In case it is necessary to be contacted about your appointment time, can you be contacted at Home? Yes__ No__

At Work? Yes__ No__
Can messages be left with others or on your answering machine? Yes__ No__ **Thank You**!