Dr. Jenna Elwart & Associates, PLLC

401 Pasadena Avenue South
St. Petersburg, FL 33707
727-495-6302 (phone) 727-202-6951 (fax)

INFORMED CONSENT TO PSYCHOTHERAPY / COUNSELING

This form is to document that I, _____, give my permission
(client or parent name)
and consent to: Jenna Elwart, Psy.D. to provide psychotherapy to:

☐me; ☐spouse; ☐child:_____.
(please mark one) (name)

While I expect benefits from this treatment, I fully understand that because of factors beyond our control, such benefits and particular outcomes cannot be guaranteed.

I understand that because of the counseling or therapy, I may experience emotional strain at times. I may feel worse during treatment and make life changes that could be distressing.

I understand that this clinician is not providing an emergency service and I have been informed of whom to call upon in an emergency or during weekend and unavailable hours.

I understand that regular attendance will produce the maximum benefits but that I am free to discontinue treatment at any time. If I decide to do so, I will notify the clinician at least two weeks in advance so that effective planning for continued care can be implemented.

As stated in the American Psychological Association Code of Ethics:

(a) Psychologists disclose confidential information without the consent of that individual only as mandated by law, or where permitted by law for a valid purpose, such as (1) to provide needed professional services to the patient or the individual or organizational client, (2) to obtain appropriate professional consultations, (3) to protect the patient or client or others from harm, or (4) to obtain payment for services, in which instance disclosure is limited to the minimum that is necessary to achieve the purpose.

(b) Psychologist also may disclose confidential information with the appropriate consent of the patient or the individual or organizational client (or of another legally authorized person on behalf of the patient or client), unless prohibited by law.

I know of no reasons why I should not undertake this therapy and I agree to participate fully and voluntarily.

Signature_____ Date_____
(Client or person authorized to consent for client)

Witness_____ Date_____

Dr. Jenna Elwart & Associates, PLLC

401 Pasadena Avenue South
St. Petersburg, FL 33707
727-495-6302 (phone) 727-202-6951 (fax)

AUTHORIZATION FOR TREATMENT AND BILLING

FEE SCHEDULE:

Intake Session -- $250 per 90-minute session
Full Individual Session -- $170 per 50-minute session
Full Family/Couples Session -- $180 per 60-minute session
Other: __$_____per _____-minute session
Payment is due at the time service is provided

THIRD PARTY PAYMENT:

I acknowledge that I have been informed and am aware of DR. JENNA ELWART & ASSOCIATES, PLLC charges for services rendered and agree to pay or authorize the third party insurer to pay those rates or their contracted portion.

I authorize direct payments of any third party insurance benefits to DR. JENNA ELWART & ASSOCIATES, PLLC for services rendered. If the third party payment benefits are not paid directly to DR. JENNA ELWART & ASSOCIATES, PLLC or are paid in an amount which is less than the agreed upon charge, or insurer refuses to acknowledge the obligation for the payment of charges for services rendered, I acknowledge my personal responsibility and agree to pay the amount of any charges for which DR. JENNA ELWART & ASSOCIATES, PLLC has not been paid through third party insurance benefits. I am aware that it is then my choice and my responsibility to seek resolution of any dispute with my insurer.

In the event that the client is a minor, I represent that I have the right and authority to authorize treatment and am responsible for payment to DR. JENNA ELWART & ASSOCIATES, PLLC for services provided to that minor.

PAYMENT:

I acknowledge that I have been informed and am aware of DR. JENNA ELWART & ASSOCIATES, PLLC charges for services rendered and agree to pay at the time of services (unless other arrangements have been made PRIOR to).

I acknowledge that I understand that payment can be made by cash or check. If I choose to use a credit card or debit card for payment, I understand that I will be charged an additional 3.5% of the cost of service. I further understand that I have the option to keep a credit/debit card information on file, which will be kept confidentially and used only when services are rendered.

NO-SHOW AGREEMENT:

There is a $85 charge for scheduled appointments that are not kept or are canceled less than 24 hours before the appointment time -- other than for emergencies (regular business days – notice given on weekends do not suffice). I understand and acknowledge that I am personally responsible for this charge. For a no-show, I agree to pay for the missed session.

Signature of Responsible Party _____ Date _____

Signature of Witness _____ Date _____