Catherine C. Olson Counseling, MSW, LCSW | P.O. 253, 815 Davis Street, Hammond, WI 54015
c.olsoncounseling@gmail.com | 651-269-0924, confidential phone

Signatures of Agreement

Client Name:_____DOB_____

Parent(s)/Guardian:_____

Informed Consent and Financial Policy

My signature below indicates that I have been provided with a copy of the Informed Consent, Financial Policy and Missed Appointment policy of my therapist. **I understand and agree that I am responsible to know details of my (or my minor child's) mental health insurance coverage and for any unpaid balances not covered by my medical insurance.** If insurance is not being billed, then I have agreed on a sliding fee.

Assignment of Benefits

I request that payment under my medical insurance plan be made to Catherine C. Olson Counseling for services provided to me or my minor child. If medical insurance is not being billed for my services, then I agree to pay the sliding fee as "out-of-pocket."

Notice of Privacy Practices

My signature below indicates that I have discussed Privacy Practices.

The forms listed above have been explained to me and I have received the opportunity to ask my therapist questions about them.

_____ _____

Signature of client or parent/guardian if under 18 years old. Date

_____ _____

Signature of parent/guardian Date