**Brooke Riehl, MA, LPC**
Licensed Professional Counselor
Marriage, Couple & Family Counseling Degree
28633 SW Coffee Lake Dr. Wilsonville, OR 97070
503.706.4775

## Informed Consent & Fee Agreement

**Client Name(s)**:_____

**Authorization and Acceptance** (Please initial all statements + sign below)

1.____ ____ I have received a **Professional Disclosure Statement** and a **HIPAA Notice of Privacy & Client Rights** for Brooke Riehl, LPC. I will review both documents and know that I am encouraged to discuss any questions with my counselor at any point in my treatment.

2.____ ____ The fees are: $125.00 (50-minute Counseling session).

3.____ ____ Preparation of reports/letters and court appearances will be billed based on the contracted session rate.

4.____ ____ I understand my use of the phone or email to communicate protected health information indicates I acknowledge and accept the possible risks associated with such communication.

5.____ ____ I understand my counselor will not be available for crisis intervention or emergencies, and I have been informed of where to call if I have an emergency.

6.____ ____ I give my consent for counseling with the above stipulations and the understanding that my counselor and I will clarify goals and objectives at any time.

7.____ ____ I accept responsibility for all financial obligations incurred with Brooke Riehl, LPC and understand payment for services are due at the time of service. I understand Brooke Riehl, LPC cannot guarantee insurance coverage/reimbursement for fees charged or collected.

8.____ ____ I accept missed appointments will be billed at the full session charge if I do not give 24-hour notice of intent to cancel.

By signing below, I agree that I have read and understand the above information and agree to the terms of therapy stated above. All questions have been adequately answered at this point in time.

My signature indicates that I am giving my consent to be treated in therapy.

My signature indicates that I am giving my consent to disclose information shared in session to mental health professionals for the purpose of consultation and supervision.

**Client Signature:_____ Date:_____**

**Client Signature:_____ Date:_____**

**Parent/Guardian:_____ Date:_____**

**Counselor Signature: _____ Date: _____**