

Tim F. Fitsimones, M.A., LMHC, CAP

Professional Counseling Services

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Licensed Mental Health Counselor

Certified Addictions Professional

Authorization to Provide Treatment

I hereby give my consent to my clinician to provide evaluation, and treatment and/or other services that we may mutually determine appropriate. I understand that my insurance company will have access to and will receive records of my treatment and that my clinician may need to discuss these to manage my care. I also understand that these services are confidential and that no information may be released without my written consent except in the following circumstances:

- 1) Information necessary to authorize services or pay claims will be communicated to the insurer/claims payer when required.
- 2) If I disclose information in the course of evaluation or treatment which indicates that I present a clear and present danger to myself or specific other.
- 3) As mandated by state law.

Late Cancellations & Missed Appointments

I agree to provide 48-hour notice of cancellation for any appointments that I have made. If I am not able to provide this notice I understand that I, not my insurance company, is responsible for payment for the time I reserved and prevented other from being able to use.

Financial Responsibility

I understand that I am responsible for all charges that are not covered by either my insurance or Employees Assistance Program.

Signed

Date