OptimalLife
WELLNESS CENTER

2320 130th Ave. NE, Suite 240, Bellevue, WA 98005
Phone: (425) 646-2778 • Fax: (425) 453-6377

CONSENT FOR SERVICES

I have received a copy of the brochure from the Department of Health entitled, *Counseling or Hypnotherapy Clients* (located on the website). I have received and read my therapist's disclosure statement and I have had an opportunity to ask questions about the course of treatment and do hereby consent to accept treatment from the therapist to whom I have been assigned. _____ **(initial)**

I received and read OptimalLife Wellness Center's HIPAA Notice of Privacy Practices. _____ **(initial)**

REIMBURSEMENT

I am responsible for paying for any services not reimbursed by my insurance company within 90 days of the date of service. I am also responsible for and agree to pay all co-pays owed, at the time of service. I assign directly to OptimalLife Wellness Center all insurance benefits otherwise payable to me for services rendered. I further authorize OptimalLife Wellness Center to release all and only information necessary to secure payment of benefits whether directly to insurance or to the subscriber of my insurance plan. _____ **(initial)**

CANCELLATIONS

Since the scheduling of an appointment involves the reservation of time specifically for me, I understand that a minimum of 24 hours' notice is required for re-scheduling or canceling an appointment. I also understand that I may be charged a late cancellation or "no-show" fee equal to the cost of the session missed for late canceled or "no-show" appointments. I understand that this fee is not billable to insurance. _____ **(initial)** In the event of extreme weather conditions, I understand that I can opt for a telehealth appointment instead of an in-person appointment, however, I will not be liable for missed sessions due to extreme weather conditions. _____ **(initial)** OptimalLife Wellness Center adheres to the Bellevue School District's decision on school closures and will contact me via phone or email to inform me of office closure.

Consent for Release to Communicate with PCP, and staff at OptimalLife Wellness Center

I hereby consent for my therapist at OptimalLife Wellness Center to communicate with my Primary Care Physician as it pertains to and is beneficial to my treatment in counseling: ☐YES ☐NO _____ **(initial)**

I hereby consent for my therapist at OptimalLife Wellness Center to communicate with other clinicians on staff who are also involved in my treatment as it pertains to and is beneficial to my treatment in counseling: ☐YES☐ NO _____ **(initial)**

_____ _____
Client's Signature Date

_____ _____
Client's Signature Date