Informed Consent & Permission for Treatment

By signing this form, you agree to receive mental health services provided by Jason Muzzillo, PLLC, dba Resolutions Therapy Practice, and independent contractors working under Jason Muzzillo, PLLC. We respect your legal right to confidentiality and will protect your information and records with the proper care. Consent forms will be required for the release of any information except in certain situations detailed below. State and Federal laws may require the release of information without written or verbal consent in the following specific situations:

1. Medical or Mental Health Emergencies
2. Clients become a danger to themselves (Suicidal thoughts/behaviors/attempts, severe depression, etc.)
3. Clients become a danger to others (Homicidal thoughts/behaviors/attempts) ** The person threatened, and the police will be notified.
4. Any report or suspected child abuse or neglect (Physical or sexual).
5. A court order or subpoena directing the release of information or testimony in a court proceeding.
6. Any litigation initiated by the client related to treatment or complaints.
7. Any abuse of the elderly, with mental illness or who cannot care for themselves properly.

Fees are due at the time of service delivery.
Cash, check, and credit card are accepted forms of payment. Clients are responsible for payment of delivered services. We will make an attempt to bill your insurance when authorized to do so. Any payments not made by your insurance provider will be your responsibility including, but not limited to: deductibles, co-pays, and any other fees not covered by your insurance provider. Assessment fees are not covered by insurance in most cases. There will be a $80 fee for appointments cancelled within 36 hours of the scheduled appointment time, with few exceptions, unless we are able to fill the missed appointment time slot. If you are a Medicaid client, we are unable to charge this fee due to Medicaid policy. If you miss more than 2 scheduled appointments without providing adequate notice of 36 hours in advance of appointment for any reason other than emergencies and sickness, you will be discharged from services with Resolutions Therapy Practice and referred to a local resource for subsequent services.

I consent to release any personal or clinical information required to process my claim to my insurance. I also authorize any payments made by my insurance company or provider to be paid directly to Jason Muzzillo, LCSW, PLLC. This form will be considered a signature on file for all future insurance claims. I understand that Jason Muzzillo, LCSW, PLLC is a Professional Limited Liability Company and not the individual Jason Muzzillo, or any independent contractors working under Jason Muzzillo, PLLC.

I understand and agree to the limits of confidentiality as indicated above. I agree to hold Jason Muzzillo, LCSW, PLLC, or any independent contractors, harmless for any loss, cost, and or damages sustained by my spouse or I. By signing this form, I hereby allow Jason Muzzillo, LCSW, PLLC, along with independent contractors, to assess, diagnose and treat mental health and or substance abuse problems for myself, my family and/or my child. I understand automated appointment reminders, if I choose to receive them, are provided as an added convenience to the patient but should not be relied upon for scheduled appointment times.

Treatment Process/Documentation:

It is the mental health professional to keep and maintain accurate records including evaluation, treatment plans, and progress notes. By signing this document, you are consenting to the treatment plan your provider creates and agree to any goals, objectives, and therapy techniques that may be used in the therapy process.

If you need to contact me between counseling sessions please contact me via phone call, text, or email. Please be advised that text messaging does have limitations in protecting confidential information. Text messaging is to be used for scheduling purposes only. Should you experience a crisis and therapist is not available, please contact 911 if you feel unable to wait to speak to the therapist directly.

_________________________________ ____________

Client Name-Printed Date

_________________________________ ________________________________

Client Signature **Parent Signature for minors under 18**

_________________________________ ____________

Therapist Signature Date

168 E Reynolds Rd., Ste 150, Lexington, KY 40517
O: 859-305-1430
F: 859-787-0531