JANE LEGWOLD, LLC

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Minneapolis, MN 55419

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CONSENT TO PSYCHOLOGICAL/ MENTAL HEALTH EVALUATION AND TREATMENT

I authorize and voluntarily consent to treatment by Jane Legwold, MS, APRN, LMFT including diagnostic procedures (e.g. psychometric tests and diagnostic interview) and treatments (e.g. psychotherapy and family therapy). I am aware that psychological/ mental health assessment and treatment sometimes entails emotional pain, stress, and life change. I am aware that the practice of psychotherapy is not an exact science. I affirm that no guarantees have been made to me regarding the outcome of the diagnostic or treatment procedures.

FEES FOR SERVICES

I understand psychotherapy sessions will consist of a 50-minute clinical hour. I understand that the fee for a clinical hour of individual, couples, or family therapy is one hundred sixty dollars ($160.00). The initial appointment has a one-time charge of one hundred seventy-five dollars ($175.00). When the session is for a longer or shorter time, the fee will be adjusted based on this rate.

FINANCIAL CONTRACT

I guarantee payment to Jane Legwold, LLC for all charges incurred or to be incurred for services rendered to me or to others at my request. All fees due are to be paid at the time of service. Unpaid bills may be turned over to a collection agency. I agree to pay all costs of collection, including disbursements and reasonable attorney's fees.

Jane Legwold is an out-of-network provider for all insurance companies. Jane is not a Medicare provider so supplemental coverage will not cover her services. Because she has opted out of Medicare, I understand that it is not an option to submit on my own behalf to Medicare or my supplemental plan. I agree to pay at the time of each session using cash, check, credit card, or my health savings account. I understand it is not an option to have a running balance on my bill. Upon request, Jane will provide a receipt that includes the needed information for you to submit on your own to get out-of-network coverage for services you received and for which you have paid. I understand that my insurance company will then reimburse me for any of those out-of-network benefits due to me under my policy. Exceptions might occur so please discuss questions with Jane. I understand that my insurance company may not regard my treatment to be medically necessary and so might refuse reimbursement. No prior authorizations will be done to assist with obtaining insurance coverage even as out-of-network services. Knowing this, I choose to receive treatment and understand that I will be responsible for payment for all services.

I also understand that I will be charged a full fee for my appointments not canceled with 24 hours-notice. If only one member of a couple shows for couples therapy, I understand that will be charged as a "no show" unless prior arrangements have been made with Jane. I agree to pay this charge.

_____ _____

Signature of Client/ Parent/ Guardian Date

_____ _____

Witness Date