Colorado Center *for*
Assessment & **Counseling**
KNOWLEDGE *to* THRIVE

phone 970-889-8204
fax 970-482-7300
web coloradocac.com

office 343 W. Drake Rd.
Suite 200
Fort Collins, CO 80526

AGREEMENT/INFORMED CONSENT

I hereby consent to enter treatment or psychological evaluation, for either myself or my child, with staff at the Colorado Center for Assessment & Counseling. I understand that therapy or evaluation is a joint effort between the clinician and client, the results of which cannot be guaranteed. Progress depends on many factors including motivation, effort, and other life circumstances. I agree that I will be responsible for the payment of all professional fees. I know that I can end my relationship with my clinician at any time I wish and that I can refuse any requests or suggestions made by my clinician.

By signing below, I am indicating that I read, understand, and agree to the information contained in the Office Policies or Group Participation Agreement document, and I have received and reviewed a copy of this office's "Notice of Policies and Practices to Protect the Privacy of Your Health Information."

I acknowledge that I have received the information listed above from my clinician at Colorado Center for Assessment & Counseling. I also understand that it is very important that I read this information carefully before our next session. I understand that I can discuss any questions I have about the procedures at that time.

Client or parent signature Date

Client or parent printed name

Therapist signature Date

INSURANCE AUTHORIZATION/RELEASE OF INFORMATION

(Signature necessary only if using insurance to pay for services)

By signing below, I authorize the release of any medical or other information necessary to process insurance claims. I also request payment of insurance benefits to the party who accepts assignment (Colorado Center for Assessment & Counseling).

Client signature Date