Susan L. Elliott, LICSW
243 Andover St.
Peabody, MA 01960

Phone: 978-532-2500 Fax: 978-532-0200

TREATMENT AGREEMENT

I, _____, give Susan Elliott, LICSW, my permission to provide Behavioral Health Services in the form of diagnosis and treatment to me and/or my child.

- I agree to pay the co-payment insurance or fee agreement in the amount of _____ at the time of each visit.
- I agree to give 24 hour notice if I need to cancel an appointment and understand that I may be charged a $25 fee if I fail to do so.
- I have been made aware of my legal rights as a client and can request at any time, further information as needed.
- I have received a copy of the *Notice of Privacy Practices* and understand that this notice describes how health information about me may be used/disclosed by my Therapist and how I can access this information.
- I assume financial responsibility for all charges received including the co-payment that is set by my insurance company. I authorize any payments of medical benefits to Susan Elliott, LICSW for any services rendered. I authorize the release of any medical information necessary to process any claims.

_____ _____

Signature of Client/Guardian *Date*

_____

Name of child (if applicable)

This authorization may be revoked at any time, except to the extent that action has been taken in reliance upon it by submitting written notice of withdrawal of consent.