TREATMENT AGREEMENT
CHASKA COUNSELING AND GUIDANCE, LLC

Client Rights and Responsibilities:

-I affirm that I have received a copy, have read and understand the Client Rights and Responsibilities document.

Notice of Privacy Practices:

-I affirm that I have received a copy, have read and understand the Notice of Privacy Practices document.

Treatment Authorization:

-I request that Lisa Knudson, LICSW, plan and provide to me treatment (or my minor child) with my participation. I understand that I may withdraw this consent and terminate treatment at any time.

-I permit Lisa Knudson to leave a discreet phone message at the phone number provided by myself on the patient registration form.

Payment Responsibility:

-I authorize Lisa Knudson/Great Lakes Medical Billing Services to process my claims with my insurance company and receive payment from my third party payer.

-I agree to pay all co-payments or co-insurance required by my health plan.

-If services I receive are not covered by a third party payer, I agree to pay for these services myself.

-I agree to provide 24-hour prior notice of any appointment cancellation. I understand that if I do not give this notice, I will be charged a $40 fee. I am aware that insurance companies will not cover this cost.

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Client Signature (or parent/legal guardian if client is under 18 years of age) Date