Andrew DiFiore, LCSW – 970 Farmington Ave. Suite 305 – West Hartford, CT 06107 – 860-748-2331

CLIENT CONSENT TO TREATMENT

____ I consent to treatment by Andrew DiFiore, LCSW for myself.

____ I consent to treatment by Andrew DiFiore, LCSW for:

____ DOB _______________
for whom I am a legal representative

____ I consent to allow the disclosure of health information necessary for reimbursement to my insurance or managed care company, Medicare, Medicaid, or other third party payor. This information will include a diagnosis and may also include specific information about my condition and the treatment process.

This consent will remain in effect for the duration of treatment with Andrew DiFiore, LCSW, or until such time as I chose to revoke it.

CLIENT FEE AGREEMENT

All co-pays, coinsurance payments, or negotiated fees are due and payable at time of service, unless other arrangements are made.

Clients are obligated to keep their scheduled appointments. Cancellations require a 24 hour notice. Cancellations without 24 hours notice or no-shows will be charged the full fee as negotiated or determined by insurance.

Co-pay, coinsurance, or fee ____________________

____ ____________________
Signature of client or legal representative **Date**

____ ____________________
Witness **Date**