

Loretta Gallo-Lopez, MA
Licensed Mental Health Counselor
105 East Giddens Avenue - Suite # 7
Tampa, Florida 33603 / 813-231-2520

Client's Informed Consent

I have chosen to receive treatment services with Loretta Gallo-Lopez, LMHC for myself/my child. If insured, these treatment services are under a benefit plan managed by my insurance carrier. My choice has been voluntary and I understand that I may terminate therapy at any time.

I understand that there is no assurance that I/my child will feel better. Because psychotherapy is a cooperative effort between therapist and client, I understand that my child and I/ I must work with the therapist in a cooperative manner to resolve difficulties. I understand that during the course of treatment, material may be discussed which will be upsetting in nature and that this may be necessary to help resolve problems.

I understand that records and information collected about me/my child will be held or released in accordance with state laws regarding confidentiality of such records and information.

I understand that state and local laws require that my therapist report all suspected cases of abuse or neglect of minors or vulnerable adults.

I understand that state and local law require that my therapist report all cases in which there exists a danger to self or others.

I understand that there may be other circumstances in which the law requires my therapist to disclose confidential information.

I understand that I may be contacted by my insurance carrier to ensure continuity and quality of treatment, and/or after the completion of treatment, to assess the outcome of treatment.

I have read and had explained to me the basic rights of individuals whose benefit plans are managed by my insurance carrier. These rights include:

1. The right to be informed of the various steps and activities involved in receiving services.
2. The right to confidentiality under federal and state laws relating to the receipt of services.
3. The right to humane care and protection from harm, abuse or neglect.
4. The right to make an informed decision whether to accept or refuse treatment.
5. The right to contact and consult with counsel at my expense.
6. The right to select practitioners of my choice at my expense.

I also agree to pay Loretta Gallo-Lopez, LMHC for all services rendered and attest that I have been notified of said charges. In the event that provided services are covered by private insurance, I hereby assign such benefits to Loretta Gallo-Lopez, LMHC under said policy and I agree to pay co-payment amounts which are my responsibility. I permit a copy of this signature to be used in place of the original on the claim form. Should my account fall into arrears, I agree to pay costs should this matter be referred to an attorney or a collection agency. I further consent to the release of information necessary to obtain payment. I understand that my therapist may disclose any and all records pertaining to my treatment to my insurance representatives (and to my primary care physician) if such disclosure is necessary for claims processing, case management, quality assurance or utilization review purposes. In addition, information to be kept anonymous may be made available to qualified personnel for research, audit, or program evaluation. I understand that I can revoke my consent at any time except to the extent that treatment has already been rendered or that action has been taken in reliance on this consent, and that if I do not revoke this consent, it will expire automatically one year after all claims for treatment have been paid as provided in the benefit plan.

I have read and understand the above.

Signature of patient/client

Date

Signature of parent, guardian, or
authorized representative

Date