Lori J. Warner, Ph.D.
Licensed Psychologist
248-217-3396 *lori@drloriwarner.com*
www.drloriwarner.com

Consent to Treatment

I seek and consent to take part in the treatment provided by Lori Johnson Warner, Ph.D. I understand that developing a plan for my treatment and regularly reviewing progress toward goals are in my best interest. I will participate actively and collaboratively in this process. I understand that there are no guarantees as to therapeutic outcomes and that I may stop treatment at any time. My only responsibility at that point would be to pay for services I have already received.

I am aware that Dr. Warner is an in-network provider for *Blue Cross Blue Shield of Michigan* (BCBSM) and Blue Care Network (BCN). She will bill BCBSM/BCN directly for services that fall within my benefit, and I understand that I am responsible for my patient responsibility. This includes all deductibles, co-payments, and/or co-insurance fees. *I understand that I am fully financially responsible for any services that are not covered for any reason by my insurance policy.*

If I have any other insurance plan, Dr. Warner operates a *fee-for-service practice*, meaning I am responsible to pay out of pocket for all services. If Dr. Warner provides me with documentation to facilitate my reimbursement by my insurance, I understand that this involves the release of limited Protected Health Information (PHI). I understand that Dr. Warner does not submit bills or claims to any insurance company other than BCBSM/BCN. I am responsible for seeking my own reimbursement, if I choose to do so.

I will call to cancel an appointment *at least 24 hours in advance* of my scheduled appointment time. If I do not cancel at least 24 hours in advance, I will be charged a late-cancel fee of $50.00. If I do not show up for my appointment, and have not called to cancel, I will be charged a no-show fee of $50.00.

Psychotherapeutic treatment involves a relationship in which I will take part in exercises and discussions intended to help me reach my personal goals and live a fulfilling and valued life. I understand that in this process, I will very likely feel an increase in distress from time to time. I will discuss this with Dr. Warner so she can facilitate my growth and help me continue to work toward my goals.

I understand that my sessions are kept confidential, unless I am at risk of harming myself or another person, or in cases of suspected child/elder abuse or neglect. I agree to disclose any thoughts of harming myself or another person, and to work with Dr. Warner to develop and implement a plan for the safety of all involved. Dr. Warner is a mandated reporter, meaning she is ethically and legally obligated to breach confidentiality if I am at serious risk of harming myself or another person.

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Signature

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Printed Name Date