

Dale Eilerman, M.Ed., PCC-S
Licensed Professional Clinical Counselor
Conflict Solutions Ohio, LLC
1563 E. Dorothy Lane, Suite 300 I,
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Phone: (937) 219-4996 Fax: (937) 293-0650

CLIENT INFORMATION AND SERVICE AGREEMENT
Client Consent to Treat - Acknowledgement of Client Rights and Privacy Policy

Client Name: _____ Address: _____
Phones: (H) _____ (cell) _____ email _____

I acknowledge that I understand the risks and benefits of treatment and the limits to confidentiality.

I understand the general process of the counseling, coaching or mediation that I am considering. I have had all of my questions answered fully and may ask further questions at any time.

I do hereby seek and consent to take part in counseling, coaching or mediation services provided by Dale Eilerman. I agree to take an active role in 1) identifying problems and concerns; 2) developing strategies and actions designed to improve client welfare; 3) utilizing recommended and collaborative methods for effecting change; and 4) assessing progress and making modifications to plans and methods as they may be appropriate.

I understand that no promises have been made to me as to the results of counseling, coaching or mediation or any interventions provided by Dale Eilerman.

I am aware that I may stop and discontinue services with Dale Eilerman at any time. If I should choose to do so I will remain responsible for paying for any services already received. I understand that if I elect to discontinue services prematurely I may lose other services or may have to address expectations associated with individuals or organizations who may have referred me for these services.

Dale Eilerman, doing business as Conflict Solutions Ohio LLC, shall be compensated at the rate of \$90.00 per hour session unless agreed otherwise. Services exceeding one hour will be billed in 10 minute increments at the rate of \$10.00 per 10 minutes. Sliding fee scales are available upon request and are based on family income level with a minimum of \$60.00 per hour. Mediation rates are a minimum of \$100.00 per hour.

Payment is due at time of services. Clients must call to cancel an appointment at least 24 hours before the time of the appointment by calling 937-219-4996. If an appointment is missed without cancellation the client will be charged for that appointment at a fee of \$60.00.

I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive. Super bills may be provided for insured clients. I understand that if my insurance does not reimburse payment to me that I am ultimately responsible for payment of the fees for services received.

I understand that if payment for the services I receive here are not made that Dale Eilerman will stop my counseling.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THE "CLIENT INFORMATION AND SERVICE AGREEMENT" AND AGREE TO ITS TERMS. IT ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED AND READ "THE HIPAA NOTICE FORM" AND THAT YOU HEREBY GIVE CONSENT FOR TREATMENT.

Signature of Client (or person acting for client)

Date

Printed Name

Relationship to Client