

**Arrowhead Psychological & Behavioral Sciences, LLC**  
**1501 14<sup>th</sup> Street West Ste 230**  
**Billings, MT 59102**  
**406-294-9510**

**Therapy Consent Form**

- I have chosen to receive services through Arrowhead Psychological & Behavioral Sciences, LLC. My participation is voluntary and I am aware that I may discontinue receiving services at my discretion.
- I understand that all information I disclose to my therapist is held in the strictest of confidentiality and may not be released without my written consent. There are some exceptions to this, which are allowed or mandated by state and federal law. Some exceptions to confidentiality include situations where there is:
  - A danger to myself or another person
  - Actual or suspected abuse or neglect of children/minors, the elderly or the disabled (My therapist is mandated by law to disclose this information to the proper authorities)
  - Presentation of a valid court order
  - Appropriate discussion of case specifics with other professionals for consultation or supervision
- My therapist may disclose any and all records regarding to my treatment to my insurance company and/or primary care physician as necessary for coordination of treatment, submission and validation of claims, or case management. I may revoke this consent in writing at any time.
- I have been informed of the costs of services. While Arrowhead Psychological & Behavioral Sciences, LLC will submit my claim to my insurance company, I understand that I am responsible for the costs of services should my insurance company not cover services. I have been encouraged to contact my insurance company to determine the scope of mental health services covered by my policy.
- I understand that I am responsible for 100% of the service fee if I should fail to give 24-hour notice to cancel an appointment.
- I understand that some of the information discussed in the course of therapy may be distressing to me, but may be necessary to help me resolve my concerns. I understand that alternatives to therapy include medication treatments or no treatment.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name (print)

\_\_\_\_\_  
Date of Birth