

Consent for Treatment

Charles Karsters LLC

Patient Information

Patient Name: _____

Phone Number: _____

Date of Birth (MM/DD/YYYY): ____ / ____ / ____

Email: _____

Photo ID Upload: _____
(Upload driver's license, state ID, or passport)

Nature of Mental Health Services

I understand therapy may involve discussing material of an upsetting nature, and that improvement cannot be guaranteed.

Compliance with Treatment Plan

I agree to participate in developing an individualized treatment plan. I understand:

- Consistent attendance is essential.
- Frequent "no shows," late cancellations, or failure to follow the treatment plan may result in termination of services.
- Sessions typically last 45–50 minutes and occur weekly or bi-weekly, unless otherwise agreed.

Limits of Confidentiality

Information shared is confidential except in the following situations:

- Signed release of information
- Legal proceedings where mental condition is relevant
- Risk of harm to self or others

- Suspected child or elder abuse/neglect
- Insurance or payment verification
- For minors under 18, parent/guardian access as allowed by law
- Referral confirmations (attendance only unless written permission given)

Client Rights

I understand my rights, including:

- Being treated with dignity and respect
- Involvement in planning or revising my treatment plan
- Knowledge of treatment progress
- Refusing therapeutic techniques and asking questions
- Communication in a language fully understood
- A clean and safe environment
- Refusing recording or photography
- Ending treatment at any time (unless court-ordered)
- Filing complaints or grievances
- Confidentiality of records as per law

Fees and Payment

Session cost: \$100–\$180 per hour

Co-payments: Average \$12 per session (Quest: no co-pay)

Missed appointment fee: \$25 for <24-hour notice

Outstanding balances: Client responsibility if insurance denies coverage

Insurance Provider (check one or more):

UHA HMAA HMSA United Health Care Aloha Care
 First Health Network Cigna Evernorth Medicare Ohana
 Magellan Blue Cross Blue Shield Tricare Other: _____

Insurance Number: _____

Client Conduct During Telehealth Sessions

Clients agree to:

- **Sobriety:** No alcohol, drugs, or impairing substances
- **No Smoking/Vaping:** Sessions must be smoke-free
- **Attire:** Professional clothing
- **Environment:** Quiet, private location; avoid lying in bed unless discussed
- **Eating:** No meals/snacks; beverages allowed

Failure to follow may result in termination or rescheduling of the session.

Emergencies

Location during sessions: _____

Emergency Contact Name & Phone: _____

I understand that for life-threatening emergencies I should call 911, and I may contact Charles Karsters LLC at 808-336-7270.

Acknowledgment and Signature

I have read, discussed, and understood all the above.

Description / Notes (optional): _____

Signature: _____

Date: ____ / ____ / ____