

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.
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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)
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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
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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: ____ / ____ / ____