New Vita Neurotherapy, LLC
101 North Lynnhaven Road, Suite 200
Virginia Beach, VA 23452
(757) 631-1300

CONSENT FOR TREATMENT AND ASSUMPTION OF FINANCIAL RESPONSIBILITY

New Vita Neurotherapy and _____ (Counselor in Residence/Intern) Have the consent of _____(Client) to provide therapeutic treatment, as deemed necessary in accordance with VA CODE 54.1-3500. Initial _____

As mandated reporters and in accordance with Virginia statutes, I/ We understand that New Vita Clinicians must report any threats regarding suicide/homicide or abuse of a child or elderly person to the authorities. Initial _____

I / We understand that financial responsibility extends to total charges, but that I / We will receive credit for any insurance benefits received by New Vita. I/ We understand that I/We are financially responsible to New Vita Neurotherapy for all treatment charges and payment is expected when services are rendered. Initial _____

I/ We promise to pay/ guarantee payment of replacement cost, plus reasonable surcharge, for all furniture or other property that may be intentionally damaged or broken through inappropriate use by the client. Initial _____

I have received a copy of the Client Bill of Rights. Initial_____

****NOTICE****

It is our policy for outpatient services to charge one half your agreed upon charge for treatment for missed appointments **NOT canceled 24 business hours prior to the appointment time**. The "No Show" fee is **not** billable to any insurance company and is the sole responsibility of the client. Initial _____

Fees for services are:

- $50 per 30-40 minutes of Neurofeedback,
- $125 for 50-minute hour with Dr. Todd,
- $50 for 50-minute hour of counseling with a Counseling Resident,
- $25 for 50-minute hour of counseling with an intern
- $75 per hour for a written report or documentation preparation for outside source.

Fees determined by income-based self pay sliding scale (for counseling services only)
$ _____ per_____. Date: _____. *(Pay stubs and other documents required, assessed every 30 days)*

_____ _____

Client Signature date ***Counselor Signature date***