Jean Kellett, LCSW
113113 Eastpoint Park Blvd. Suite G
Louisville, KY 40223
502-423-0509
jean@jkellett.com

Permission to treat:

I acknowledge that it is my choice to participate in psychotherapy (or have my child participate). I will take responsibility for my psychotherapy and will come prepared and ready for each session. I will discuss termination prior to ending treatment.

Before you sign below, please ask any questions you may have of this document. Thank you for your courage to come and for your strength in discovering more about yourself. **Your signature acknowledges agreement and understanding.**

_____ _____

signature of client date

_____ _____

signature of therapist date

INSURANCE COMPANY _____ Phone#_____

POLICY HOLDER _____ SSN#_____ DOB____/____/_____

RELATION TO CLIENT _____ EFFECTIVE DATE ____/____/_____

POLICY # _____ GROUP # _____

Your mental health claims are GENERALLY PAID THROUGH A COMPANY OTHER THAN YOUR INSURANCE COMPANY. You must call the INS. Co. and ask for this information! It is not the address on your insurance card. Please note: until all this information is provided, you are responsible for payment.

MENTAL HEALTH CLAIMS COMPANY _____ PHONE # _____/_____

CLAIMS ADDRESS _____

REF# AUTH# _____ # OF VISITS _____

CO/PAY AMT. $ _____ DEDUCTIBLE AMT. $___ _____ MET/NOT MET_____

I hereby authorize my insurance benefits to be paid directly to Jean Kellett, LCSW. ***I RECOGNIZE THAT I AM RESPONSIBLE FOR PAYMENT OF NON-COVERED SERVICES AND NO-SHOW FEES.*** *I also authorize the release of any pertinent medical information to the above named insurance company to assist in claim payment.*

Signature of Client: _____ *Date:* _____

Custodial Parent /Legal Guardian Signature: _____ *Date:* _____