

SERVICES AGREEMENT

- I.
I understand that the clinical experiences, professional training, and therapeutic styles of private therapists are both varied and quite diverse. Some styles may be more effective and/or appealing for some clients. My clinician has discussed with me the styles and approaches he/she uses.
- II.
a. I understand that if at any time, for any reason, I should decide that I do not want to continue seeing this clinician for services I can stop. I participate and attend these counseling services voluntarily and do so completely of my own free will.
b. Likewise, if at any time my counselor feels that I would be better served by a different provider/service or that we have reached the maximum expected benefit from the services being provided, he/she may decide to terminate services. Should this be the case, my counselor will discuss this and the transition process with me, and will provide me with a minimum of three referrals that may be more appropriate to my counseling/emotional health needs.
c. I understand that services with this provider may be terminated and referrals for other providers given to me if I miss 3 or more scheduled sessions without calling to cancel as listed in VII / re: the cancellation policy.
- III.
If I should decide to terminate services, I agree to notify my therapist, preferably in person/session, but at least within the bounds of the cancellation policy noted herein. At the time I choose to terminate services, my clinician can provide me with alternate referrals at my request.
- IV.
I will not attend any session while under the influence of alcohol or drugs, including prescription medications used other than expressly directed by my prescribing physician and over-the-counter medication used other than as directed by the container and/or pharmacist.
- V.
I will not bring any weapon; firearm or other, into the building, even if I hold a concealed handgun permit or other permit granted under my profession. This includes pepper spray or "mace". I understand that bringing any weapon into the building is grounds for immediate termination of services, contacting the authorities, and filing of formal charges. I also understand that the building management may also pursue legal action re: weapons on the property.
- VI.
I understand that for continuity of care purposes, I will be requested to provide a listing of all medications I am currently taking, the physician who is prescribing them, and to sign a two-way release of information (ROI) for my counselor to speak with my physician, should the need arise. Refusal or misrepresentation of information re: medical professionals and prescriptions/medications may result in termination of any further services from this counselor/counseling office.
- VII.
I understand that the cancellation policy for this office is a minimum of 48 hours *prior* notice to the scheduled appointment. If I am unable to or unsuccessful in notifying my counselor that I will not make an appointment, I will be charged a Late Cancellation/No-Show fee of \$75.00 This charge must be paid in full before my next appointment.
- VIII.
I understand that I cannot bring any other party into a session without prior discussion with my counselor. This includes family and significant others.

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IX.

I understand that my counselor may decline to provide services to any minor without the parent/legal guardian present in the sessions. It is my counselor's contention that in most cases, treating a minor without the involvement of the family/parent/guardian does not often provide long term improvement gains for the minor. This can be discussed more in depth on an individual basis with my counselor.

X.

I understand that I cannot leave any child / minor unattended in the hallways or waiting area and will need to make prior arrangements for their supervision or care. Children may not be brought into a session unless they are receiving services and only in accordance to the above stipulation re: the treatment of minors.

XI.

I understand that the standard "billable hour" for an individual private therapy session lasts 45-50 minutes. This service is coded as a 90806 by insurance companies. The standard rate for this service by my clinician is \$150.00. I understand and agree to pay this fee for the services rendered. (I understand that services other than 90801:Initial Assessment and the 90806:Standard Session have *different* fees. Should I decide to receive these services, it is my responsibility to discuss the rates with my counselor prior to accepting the services.)

XII.

If my counselor accepts my insurance, I understand that if I should choose not to use it, for any reason, I release any right to retrospectively submit claims to my insurance at a future date. This poses a significant hardship for the counselor's office and many hours to conclude. By signing this agreement I understand that unless I alert my counselor and provide him/her with a copy of my insurance information I will be fully liable for all fees and waive all rights to retrospectively bill to my insurance.

XIII.

If my counselor does not accept my insurance, I can request a receipt which I may submit to my insurance to seek reimbursement; in full or part. My counselor will ONLY provide receipts for services and dates actually provided. If I initially decide I do not want receipts, and later decide that I want receipts generated retrospectively, there will be a processing fee.

XIV.

My counselor does not routinely provide documentation/written services. Exceptions to this may be made on an individual basis, as determined by your counselor. In the event an exception is made, the fee for the first page of the document is \$50 and subsequent pages are \$25 per page. This includes all documentation requiring signatures. These services may only be paid for in cash or via credit card, if applicable, and must be paid at the time documents are received. My counselor will *not* be available to sign any documents re: disability – these will need to be addressed through your physician.

XV.

Any and all time spent by the clinician in relation to any legal proceeding is at a rate of \$650 for the first hour or any part thereof and \$325 per hour for every subsequent hour *in the same* 24 hour period. This begins at the time clinician leaves home/office and continues until the time they return. By signing this agreement, you agree to be solely and fully responsible for all payments due, should the clinician or other member of this office, be required or requested to be involved in any legal proceeding; including but not limited to mediation, court/trial, depositions, and for consultative services.

XVI.

I understand that my counselor does not personally provide emergent / on call services. For emergency/crisis situations I understand that I will need to call 911 or proceed to the nearest emergency room.

XVII.

I understand that my counselor does not provide "phone-based counseling" or "phone therapy". Routine calls and texts for scheduling purposes are part of the business and expected. Non-scheduling phone calls are considered "Non-Clinical Consultative" sessions which are billed at \$1.00 a minute, must be paid in full prior to next appointment, and are not covered by or billed to managed care / insurance plans.

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By signing this document, I attest that I have read and understand, or have had it read to me and fully understand, all of the above and agree to abide by it in its entirety. I attest that I have signed this document only after discussing any/all questions regarding the above statements with my counselor to my full satisfaction.

Signature

Date

Witness

Date

Parent/Guardian of Minor

Date