

## CLIENT SERVICES AGREEMENT

This document contains important information about our professional services and business policies. Please read it carefully. Once you sign this, it will constitute a binding agreement between us.

### COUNSELING SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personality of both the therapist and the patient and the particular problems that the patient brings. There are a number of different approaches that can be utilized to address the problems you hope to address. It is not like visiting a medical doctor, in that it requires a very active effort on your part. In order to be most successful, you will have to work both during our sessions and at home.

Psychotherapy has both benefits and risks. Risks sometimes include experiencing uncomfortable levels of feelings like sadness, guilt, anxiety, anger and frustration, loneliness and helplessness. Psychotherapy often requires recalling unpleasant aspects of your history. Psychotherapy has also been shown to have benefits for people who undertake it. It often leads to a significant reduction of feelings of distress, and better relationships and resolutions of specific problems.

If psychotherapy is initiated, we will usually schedule one forty-five to fifty-minute session (one appointment hour of 45-50 minutes duration) per week at a mutually agreed time, although sometimes sessions will be longer or more frequent.

**Please read and initial each of the following:**

#### \_\_\_\_\_ PROFESSIONAL FEES

The regular hourly rate for psychotherapy services varies in range from \$100 to \$150. In addition to weekly appointments, it is our practice to charge this amount on a prorated basis for other professional services you may require such as report writing, telephone conversations that last longer than 15 minutes, attendance at meetings or consultations with other professionals which you have authorized, preparation of records or treatment summaries or the time required to perform any other service that you may request of me. In unusual circumstances, you may become involved in a litigation that may require your therapist's participation. You will be expected to pay for the professional time even if he/she is compelled to testify by another party.

#### \_\_\_\_\_ APPOINTMENT SCHEDULING AND CANCELLATION

Cancellation of scheduled appointments is required 24 hours in advance. **If you do not cancel 24 hours in advance or do not appear for a scheduled appointment, you will be charged the full hourly fee,** unless we both agree that you were unable to attend due to circumstances beyond your control.

If you do not appear for a scheduled appointment, you will be charged the full hourly fee for two reasons:

- 1) We maintain a waiting list of clients who require appointments. If you cancel 24 hours in advance, we will be able to fill your appointment with another client.
- 2) Insurance companies do not reimburse therapists or clients for missed appointments; therefore you will be liable for our full fee, not your standard co-pay amount.

## **BILLING AND PAYMENTS**

You will be expected to pay for each session at the time it is held, unless we agree otherwise. Payment schedules for other professional services will be agreed to at the time these services are requested.

If you did not pay at the time of service and your account is more than 30 days in arrears, a service charge of \$5 per month will be charged to your account. If your account is more than 90 days past due and suitable arrangements for payment have not been agreed to, we have the option of using legal means to secure payment, including collection agencies or small claims court. If such legal action is necessary, the costs of bringing that proceeding will be included in the claim. In the event that your balance due is turned over to a collection agency, a 30% service charge will be added to the balance of the account. In most cases, the only information that is released about a client's treatment would be the client's name, the nature of the services provided, and the amount due.

## **INSURANCE REIMBURSEMENT**

If your therapist is a network provider with your mental health insurance carrier, our office will submit claims for payment on your behalf. You are responsible for any co-payments, co-insurance, and deductibles required by your health plan.

If your therapist is not a network provider with your mental health insurance carrier, our office will assist you by completing our portion of a claim form. You are responsible for completing your portion as well as mailing it to the insurance company and tracking your reimbursement. We do not accept assignment of benefits from insurance carriers whose panels we are not affiliated with. Your therapist will gladly discuss your proposed treatment with your insurance company if they call us and you provide us with a signed release. **We will not call to request authorizations.** You are responsible for the full fee regardless of your insurance company's reimbursement policies.

## **CONFIDENTIALITY**

In general, the confidentiality of all communications between a client and a licensed professional counselor is protected by law, and your therapist can only release information about your work to others with your written permission. However, there are a number of exceptions.

In some judicial proceedings, you may have the right to prevent information about your treatment being provided. However, in some circumstances, such as child custody proceedings and proceedings in which your emotional condition is an important element, a judge may require testimony of the therapist if he/she determines that resolution of the issues before him/her demands it.

There are some situations in which your therapist would be legally required to take action to protect others from harm, even though that requires revealing some information about a client's treatment:

- If the therapist believes that a child, an elderly person, or a disabled person is being abused, he/she must file a report with the appropriate state agency.
- If the therapist believes that a client is threatening serious bodily harm to another, he/she is required to take protective actions, which may include notifying the potential victim, notifying the police, or seeking appropriate hospitalization.
- If a client threatens to harm him/herself, the therapist may be required to seek hospitalization for the client, or to contact family members or others who can help provide protection.

Should such situations occur, your therapist would make every effort to fully discuss it with you before taking any action.

Your therapist may occasionally find it helpful to consult about a case with other professionals. In these consultations, he/she will make every effort to avoid revealing the identity of his/her client. The consultant is, of course, also legally bound to keep the information confidential. Unless you object, your therapist will not tell you about these consultations unless he/she feels that it is important to your work together.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that you discuss any questions or concerns that you may have with your therapist. As you might suspect, the laws governing these issues are quite complex and your therapist is not an attorney. While he/she will be happy to discuss these issues with you, should you need specific advice, formal legal consultation may be desirable.

### **\_\_\_\_\_ CONTACTING YOUR THERAPIST**

Your therapist is often not immediately available by telephone. Anytime you need to speak to your therapist, you may call our main line at 636-498-0700. You will be able to leave a voicemail message that your therapist will return at their earliest convenience. If you cannot reach your therapist, and you feel that you cannot wait for your call to be returned, you should call your family physician or the emergency room at the nearest hospital and ask for the psychologist or psychiatrist on call. If your therapist will be unavailable for an extended time, he/she will provide you with the name of a trusted colleague whom you can contact if necessary.

At times you may choose to communicate with your therapist via text message, email, or through other electronic means. Please be advised that this is not a secure means of communication and confidentiality can not be guaranteed. Regarding social media: We do not accept or respond to friend requests from current or former clients on social networking sites, as this may compromise confidentiality, threaten the integrity of treatment, and blur the boundaries of our therapeutic relationship.

### **\_\_\_\_\_ MINORS**

If you are under eighteen years of age, please be aware that the law may provide your parents with the right to examine your treatment records. It is our policy to request an agreement from parents that they consent to give up access to your records. If they agree, your therapist will provide them only with general information on how your treatment is proceeding unless he/she feels that there is a high risk that you will seriously harm yourself or another, in which case, your parents will be notified. Your parents will also be provided a summary of your treatment when it is complete. Before giving them any information, your therapist will discuss the matter with you and will do the best he/she can to resolve any objections you may have about what has been prepared to discuss.

### **Your Informed Consent to Care**

This information has been provided to you in the hope of fully informing you about the policies of this office and some of the parameters of care you will receive here, such as the importance of confidentiality. Please feel free to discuss any of these matters with your therapist in more detail.

By signing below, you acknowledge having read, understood, and agreeing to these policies and procedures. Your signature acknowledges your informed consent for care. It is recommend that you print a copy of this form for your records.

\_\_\_\_\_  
Signature of Client

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Guardian if Client  
is Less than 18 Years of Age

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness/Therapist

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

## FEE AGREEMENT

Check one of the following statements:

\_\_\_\_ I am covered by mental health insurance for which my therapist is an in-network provider. I understand that he/she will seek reimbursement from my mental health insurance carrier and will track reimbursement. I hereby authorize the release of any information necessary to process health insurance claims and assign payment of such benefits to my therapist.

\_\_\_\_ I am covered by mental health insurance for which my therapist is an out-of-network provider, will be seeking reimbursement for services, and am requesting services at the regular hourly rate. I understand that my therapist will complete the provider's portion of a health insurance claim form at least once every four visits and at my request and will provide such form to me. If for any reason I have not paid in full for services received, I hereby authorize the release of any information necessary to process the necessary health insurance claim and assign payment of such benefits to my selected therapist.

\_\_\_\_ I do not have insurance covering mental health treatment.

\_\_\_\_ I am covered by mental health insurance but, at my option, choose not to seek reimbursement for services. I understand that I will be receiving services from my therapist at the full hourly rate or at the negotiated rate of \_\_\_\_\_.

**I agree to pay the hourly or negotiated rate for any professional services performed (as outlined under PROFESSIONAL FEES on page 1 of the Client Services Contract) during the course of my treatment. If my treatment is covered by my mental health insurance, I agree to pay my portion of the fees for service as outlined by my insurance company.**

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date