

Ravenswood Counseling Center Center
Statement of Agreement for Psychotherapy Services
2019

1. ***This is your therapy.*** We will work together at establishing your goals and will regularly evaluate your progress to ensure that you are getting what you need and want.

Your participation is voluntary. The work has benefits and risks, with no guarantee of outcome. The process may reduce feelings of stress and anxiety, along with possibly experiencing uncomfortable feelings that may be upsetting. You are free to withdraw consent for participating at any time. An appropriate discussion of ending the therapeutic relationship will follow.

2. ***It is important that you be aware of my background and training.***

I will explain this during our first session, but you are always free to ask for additional information at any time.

3. ***The fee for a fifty-five minute session is _____. This fee is payable at the time of each session and may be made by credit card, check or cash. You will be responsible for payment for sessions each time we meet.***

Partial payment for each session can be arranged on an individual basis. Unfortunately, if you arrive late, I will still need to end our session at the scheduled time. If I am late, I will ensure that you receive a full fifty-minute session. If you make payment by check and the check is returned due to insufficient funds, or if your credit card is declined after two attempts, you will be charged \$20.00 in addition to your regular session fee. Fees will be reviewed annually from the date of the first appointment.

4. ***Please give 48 hours notice to cancel an appointment.***

If you cancel a session without 48 hours notice, you will be charged for the session—even if your cancellation is work-related. If you have arranged to pay by credit card, your card will be charged the equivalent of one session based on the pre-determined self-pay rate or the contracted reimbursement rate of the insurance company being utilized. There may be special circumstances (dire illness or weather events) when 48 hours notice is not possible and we will discuss these on an individual basis. If you are ill, please do not wait until the time of your session to decide you are too ill to attend. If your cancellations create scheduling difficulty, it is possible that I may not be able to provide you with a regular appointment day and time. If cancellations interfere with effective therapy, I may ask that you re-think your willingness/ readiness to engage in this process

5. ***I am available to you by phone should problems arise and am happy to talk with you.*** There is no fee for phone calls between sessions less than 10 minutes. Any calls that are 10 minutes or longer will be considered partial sessions and will be billed according to your fifty minute session fee (on a prorated basis). I will make every effort to return your call within 24 hours it is made.

6. ***There will be times when I am out of town.*** During these periods, I may be reachable on an emergency basis only. When I know I will be unavailable, I will provide you with as much notice as possible.

7. ***A separate fee will be negotiated for any reports or evaluations that you may need for personal and/or legal purposes.***

Any report writing for insurance purposes or court purposes, or any appearances in court or depositions will be billed to you at twice your hourly rate.

8 I will communicate with your primary healthcare provider, psychiatrist or any other individual only if you give me permission through signing a consent form to release information.

Your therapy is confidential to the extent allowable by law. Only in instances in which your safety is in jeopardy, others' safety is in jeopardy, or you disclose that you have hurt a child or elder am I required to take action. If you have not seen a primary healthcare provider, it may be possible that I will recommend that you receive a physical examination to determine if there are physical issues that contribute to your mental health. My signature below also confirms that I was offered a copy of the therapist's privacy policies as outlines in the Health Insurance Portability and Accountability Act (HIPPA).

Client Signature Date

Client Signature Date

Therapist Signature Date