New Hope
COUNSELING CENTER

Please complete each page and email your PDF to:
becky@newhopecounselingcenter.org

# Client / Therapist Agreement

**Now, please take a moment to read this overview of mental health services and indicate that you understand our policies by checking each box as you read it.**

☐ **Confidentiality**
Under state and federal law, your counseling records are protected. Thus, the content of our sessions is strictly confidential. Information about you cannot be released without your written consent. However, under mandated law, there are exceptions to this confidentiality. These exceptions include threat to harm self or others, child abuse/neglect situations, aging adult abuse/neglect, and court orders from a judge to release information. Additionally, insurance carriers often request and require oral or written case summaries as a condition of reimbursement. Also, if you were referred to me by another professional, I would like to notify them of your contact with me, unless you instruct me otherwise.

☐ **Fees and Billing Policy**
**All fees are due at the time services are provided.** In general, all sessions are billed at $130 per 45 minute ("clinical hour") session. Different fee schedules exist for longer evaluations, testing, expert witness fees, consultations, and test interpretations. You may pay by cash, check, credit card, cashier's check, or money order. Upon payment of cash, you will receive a receipt to keep for your own records. In the event that a check should be returned, you will be responsible for paying any fees that are charged to me by my banking company, in addition to the original amount owed. (This payment may be made by cash or cashier's check only.) Account balances that exceed $500 will need to be reviewed with your therapist before scheduling further appointments.

☐ **Insurance Billing Policy**
**If you choose to use your insurance plan**, you will be encouraged to pay for services rendered at the time of service. If you are unable to pay the full amount, review your financial concerns with your therapist. Please be aware that if you do elect to assign your health benefits, your insurance company will require that I submit diagnostic and clinical information. While such information is very sensitive and generally treated as such by insurance carriers, I cannot guarantee how any particular insurance carrier or employer will respect the information. Additionally, there will be times that your insurance company will seek more information before giving further authorizations for reimbursement. At those times, it will be necessary to use part of your clinical sessions completing the necessary paperwork and providing them with the requested information.

☐ **Authorization to Release Information and to Pay Benefits**
By signing below, I agree to authorize New Hope Counseling Centers to release any of my behavioral health information, including any drug and alcohol history, to my insurance company, as needed to process my insurance claim. In addition, I authorize my insurance company to make payments directly to New Hope Counseling Centers for covered behavioral health services.

☐ **Appointments**
My services are provided by appointment only. In as much as possible, I will work with you on providing convenient appointment times. The length of the appointment is generally schedules for 45-50 minutes, allowing 10-15 minutes of the hourly charge for preparation and record keeping.

☐ **I require a 24-hour notice for cancellations,** otherwise you will be charged.
I know that unpredictable circumstances do arise and will allow for one emergency cancellation for which you will not be charged, upon my discretion. *Please be aware that insurance carriers do not reimburse for missed appointments.* If you know that you will need to cancel an appointment, please call and we will work together on rescheduling your session at a more convenient time and date. In the event that you arrive late for an appointment, only the remainder of that appointment time can be carried out. With this policy, it is intended that you, as well, will not be inconvenienced and seen later than scheduled by a previous client's late arrival.

☐ **Messages**
You will find that I do not accept calls while I am in session with you, or while I am with other clients. During those times, or when I am out of the office, messages can be left with the office staff or on my voice mail. I will make every effort to return your call as soon as possible. **Please note, New Hope Therapists do not use email or text to convey or receive clinical information!**

**Confirmation of Appointments**
By signing below, I agree to all New Hope Counseling Centers to contact me at the following number(s) to confirm, make, or change appointments:

Phone #'s: _____ or Email address: _____

Alternate phone #: _____ or Email address: _____

I also ○**agree** / ○**don't agree** (please check one) to allow New Hope Counseling Centers to leave a message regarding our appointment, if I am not available at the time of the call.

******* THIS FOLLOWING SECTION WILL BE FILLED OUT IN PERSON *******

**Monthly Statements**
By signing below, I agree to authorize New Hope Counseling Centers to send monthly statements to my provided home address, as well as provided email addresses, in the event that I have a balance owed.

**Consent for Treatment**
By signing below, I acknowledge that I have read the Notice of Private Practice as part of the HIPPA Policy requirements.

If you have any questions or concerns regarding any of this material, please do not sign until we have discussed it and I have answered all of your questions.

_____ _____
Patient Signature | Responsible Party's Signature (if patient's under 18)

_____ _____
Printed Name of Patient | Printed Name of Responsible Party

_____ _____
Witness Signature (For office use only) | Date

_____
Printed Name of Witness

**FOR OFFICE USE ONLY:**

**We attempted to obtain written acknowledgement of receipt of our Notice of Private Practice, but Acknowledgement could not be obtained because:**

☐ **Individual refused to sign**

☐ **Communication barriers prohibited obtaining the acknowledgement**

☐ **An emergency situation prevented us from obtaining acknowledgement**

☐ **Other (Please specify):**