

THERAPY CONTRACT

Welcome to my practice. I will make every effort to assist you in resolving your individual and relationship concerns. The information below outlines practical material pertaining to treatment, appointments, and fees. Please read through this information.

I will answer any questions you may have and ask you to sign the second page.

APPOINTMENTS

I understand that appointment times are set aside for my use alone and cannot be used by the therapist for any other purpose. I understand that each therapy session lasts 45 minutes unless special arrangements have been made. I understand that once I have scheduled an appointment, it is my responsibility to enter the appointment date or time in my calendar and to keep track of it. There will be no reminder call. If you require appointment confirmation, please call or text.

FEES

I, _____, agree to pay the following compensation for each:

45-minute individual/couples session: \$_____

60-minute individual/couples session: \$_____

90-minute individual/couples session: \$_____

I understand I am responsible for payment for each therapy session at the time of the session. If I wish to pay monthly, I may pay for the month in advance.

INSURANCE

I understand that I am responsible for all payments. It is I who is being billed for the services I receive and not my insurance company, even if I have insurance covering the service.

I understand that insurance companies require a medical diagnosis in order to process claims and reimburse fees. The therapist will discuss these diagnoses with me.

CONFIDENTIALITY AND RECORDS

I understand that my therapist will keep all information developed in our sessions strictly confidential unless I give written permission to the contrary or in the event that I am threatening to kill myself, kill someone else, or there is reasonable evidence to suggest that a child or disabled adult is being abused. Only after careful deliberation and where there is clear and imminent danger will the exception be made.

I understand that my records will be retained for no more than four (4) years following the terminations of treatment. They will then be destroyed unless there have been further interactions or therapy between us.

I understand that I have access to these records unless the therapist feels that some of this information could endanger myself or others. I may ask for copies of the files but must assume the cost of photocopying.

I understand that I may not alter the files by deleting information, but I may add addenda to the records to correct or add information.

MISSED APPOINTMENTS

I agree to keep all scheduled appointments. I understand that I will be billed for my scheduled time unless alternative arrangements are made at least **48 hours** in advance. Personal or work emergencies will be treated the same in applying this cancellation policy. I understand that my insurance will not cover the fee for missed appointments and I must pay the full fee, not just the co-pay, for missed appointments.

I understand that my therapist will wait **20 MINUTES** beyond my scheduled appointment time. After 20 minutes the appointment will be considered cancelled.

The practice telephone is covered by a time/date-stamped answering service 24 hours a day, 7 days a week for your convenience in leaving messages regarding your appointments.

IN CASE OF BAD WEATHER

I understand that if my appointment is scheduled during a time that the schools and government are closed because of bad weather that my therapist may reschedule my appointment or we may opt to do the session over the phone. The client is responsible for calling about this. Failure to do so will result in a missed session.

EMERGENCIES

Occasional emergencies may occur that require a phone consultation. For calls under 15 minutes there will be no charge. If, however, the call is longer than 15 minutes or the calls become a frequent situation, a fee will be charged in 15 minute increments. If you are unable to reach the therapist quickly, and there is an immediate danger to life or health, please call 911 or go to your nearest emergency room.

SOCIAL MEDIA

I do not use social networking sites such as Twitter, Facebook, or LinkedIn. I do not search for clients on Google or Facebook or other search engines.

EMAIL

I check my e-mail twice a day: in the morning and in the evening. The best way to contact me is by phone at 202-441-0091. Do not use email to communicate with me in the event of a crisis or emergency. If you are unable to reach me by telephone, please go to your nearest emergency room or call 911.

If you choose to communicate with me by email to address scheduling or other concerns, be aware that all emails are retained in the logs of your and my internet service providers. While it is unlikely that someone will be looking at these logs, they are, in theory, available to be read by the system administrator(s) of the internet service provider. You should also know that any emails I receive from you and any responses

that I send to you will become a part of your legal and health record. You assume responsibility for any accidental disclosure of personal information as a result of others having access to your email accounts, including your employer.

TERMINATION OF TREATMENT

I understand that I can terminate at any time, for any reason, and without penalty. However, I understand that given the importance of the therapeutic relationship, it is important to discuss with my therapist in advance of my desire to terminate so that there is an opportunity to reach a mutual decision and to have a termination session.

I understand and agree to all these policies:

_____ (Client) _____ Therapist

_____ Date

AUTHORIZATION TO CONTACT THE REFERRING HEALTH PROVIDER/ AND INSURANCE COMPANY

I authorize my therapist to contact (for the purpose of treatment coordination) the physician or therapist who referred me.

_____ (Client)

I authorize my therapist to release requested information to my insurance carrier and/or managed care company. I understand that failure to give this authorization may result in denial of claims.

_____ (Client)