Advanced Counseling Services Contract for Services and Client Information

Policies and Procedures

FEES: **$ 150.00 for initial assessment and $120.00 for subsequent sessions.** This fee is subject to change**. Fees will cover one (1) clinical unit of service which consists of 50 minutes of direct service. For clients using insurance, the clinical unit is determined by your insurance company.** Payment for counseling services is the responsibility of the client, and expected at the time of service.

INSURANCE: In many instances insurance benefits may be available that cover a portion of the client's fees for counseling services. The client is responsible for supplying adequate information for our office to file the insurance claim for any applicable reimbursement. The client is also responsible for any notification/pre-authorization requirements that may be applicable to receive benefits**. Please consult with your insurance carrier or employer regarding your coverage. Ultimately, the client is responsible for any portion that insurance does not cover because of co-payment or deductibles. We may ask for the first session to be paid in full in order to cover any deductible or copays if coverage has not been verified. After the first session, we still expect payment at each session to cover your co-pay or deductible. Any overpayment will be reimbursed to you as soon as possible. Secondary Insurance: If you have primary & secondary coverage, we will treat your payment due at each session as if you only had primary insurance.**

PARENTS: The parent that brings the child in for counseling and signs the contract will be responsible for all fees. We will not provide split billings for parents.

CONFIDENTIALITY: Communication between the counselor and client are privileged. Information regarding client services will not be released to any party or agency without explicit written approval on the part of the client. There are, however, several special circumstances which are exceptions to the rules regarding confidentiality:

1. If fees are reimbursed by a third party (such as an insurance company), certain details of treatment (e.g. dates of treatment and diagnosis) must be released to the third party to adequately process the claim.
2. If a client reveals information that indicates a clear danger of injury to themselves or to others, the counselor will contact appropriate authorities or family members.
3. Pursuant to New Jersey Law, counselors have a legal responsibility to notify appropriate social agencies of the suspicion or knowledge of physical or sexual abuse or neglect of a child, a disabled person, or an elderly person.

APPOINTMENTS: Your scheduled appointment is reserved time specifically for you. Twenty-four (24) hour notice to cancel or reschedule appointments is expected. Failure to notify the office of canceled appointments may result in a bill for no show or late cancellation fees.

Contract

❑ I understand and agree I am entering into a counseling relationship. The nature of the services available to me will be dictated by my individual needs and my active participation in a therapeutic relationship between myself (or others) and my counselor.
❑ I understand and agree the length and frequency of my counseling will be determined by my progress and treatment needs, and will be determined in collaboration with my therapist.

❑ As with any type of treatment, I understand there is no guarantee for complete and permanent resolution of my clinical issues, and agree to notify my counselor if our sessions are not beneficial.

❑ I understand and agree my counselor may make referrals to other professionals (e.g. psychiatrists) with my approval.
❑ I understand and agree I have the right to terminate, withdraw, or refuse my consent to treatment.
❑ I understand and agree my consent to receive treatment is active as of the date of this contract, and my participation is voluntary and remains in effect for no longer than 180 calendar days following my last scheduled appointment.
❑ I understand and agree I cannot require testimony from the counselor with regards to child custody cases.
❑ I understand that my counselor will charge $300 per hour for all other court appearances on your behalf and an additional charge for mileage.
❑ I understand that my **sessions are time set aside specifically for my individual treatment and late cancellations (anything less than 24 hours) will result in half of my hourly fee and any cancellations made within 3 hours of my scheduled appointment or no shows will result in the full hourly fee. I further understand that these fees will be applied to the credit card I leave on file or I can set up**
a payment arrangement with my therapist.
❑ **I understand that I will be charged $60 for any letters I request my therapist to write on my behalf.** An exclusion to this understanding are letters written to other treatment providers in order to coordinate treatment or letters written to collect money from insurance companies, etc.
❑ I understand that **I will be charged my treatment hourly rate for any phone calls I request my therapist to either accept or make on my behalf (regardless of amount of time spent on the phone).** An exclusion to this understanding are calls made to other treatment providers in order to coordinate treatment and calls made by the provider to collect payment from insurance companies, etc.

❑ **I understand and agree a fee of $60 will be charged for any email or text correspondence not generated by my therapist.** An exclusion to this understanding are texts and emails sent to either schedule or reschedule a session.
❑ **I understand that if I am the parent of the client, I agree at the request of the therapist to schedule sessions with or without my child to discuss progress or lack thereof.**
I have read and understand the above policies and procedures. I understand that these professional services are rendered for my benefit and/or the benefit of my spouse and/or those in my guardianship. Services will be provided at a rate set by my insurance company. Fees for services will be billed directly to me. I understand that payment for services is my responsibility and is expected at the time of service. If insurance is available, I understand that I am responsible for any balance not paid by insurance. Any financial arrangements other than the above standard procedures must be negotiated with the counselor and put in writing at the time of this agreement. Failure to honor this agreement may result in this account being assigned for collection proceedings and the client will be responsible for any additional related expenses related to the collection proceedings. Further, if insurance is available, I authorize the release of any medical or other information necessary to process this claim with my insurance company. I also authorize payment of medical benefits to the provider of services listed above. I have received and read the Notice of Privacy Practices and agree to let the counselor use my information as outlined in the Notice.

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Printed name of Client Date Signature of Client Date

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Printed name of Guardian Date Signature of Guardian Date

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Witness signature Date