Life's Light and Hope, PLLC Sara E. Collins, LMSW
Phone: (734) 582-4294
Text: (734) 265-0554
Fax: (734) 468-0106

Treatment Contract

I acknowledge that I am voluntarily authorizing treatment for myself, or my child, upon the premises of ***Life's Light and Hope, PLLC.***

I understand that treatment will be rendered by appropriate professional personnel:
Sara E. Collins, LMSW.

- I may contact the therapist as the need arises at the telephone number or address provided to me.
- Successful termination of treatment is determined when the therapist and the client agree that the treatment goals have been substantially completed.
- There are fees for the services rendered and I have been informed of those charges and that I am responsible for those charges.
- If a check is returned NCF or uncollectable, any/all bank fees, plus a processing fee of $35.00, will be added to the amount due and owing.
- If I am entitled to insurance payments for this treatment, my therapist may assist me, but assumes no responsibility for collecting them
- If there is a balance on an account for which I am responsible, is not paid on monthly and/or the outstanding balance on my account is deemed too high by ***Life's Light and Hope, PLLC*** the therapist may cancel therapy sessions until the balance is brought up to date; however, the therapist will inform me of this practice no less than 24 hours before the scheduled appointment.
- **If I, the client, elect not to keep or cancel a therapy session less than 24 hours prior to the scheduled time, the therapist may charge me for this appointment. I recognize that my insurance will not cover this charge of $25.00. Any charges for late cancellations or missed appointments must be paid at the time of the next scheduled appointment.**
- If, in the event that my account is submitted for collections, all applicable fees will be assumed by me.
- The services offered by the therapist and the hours of operation have been clearly explained to me. In general, they are outpatient services for mental health issues. The therapist operates– Tuesday and Thursday from 1:00pm – 9:00pm and Friday from 2:00pm – 6:00pm. Availability on Monday from 2:00pm – 6:00pm and the first Saturday of every month by special appointment only.
- As a client I understand that I have certain responsibilities which include the following:
  - The responsibility to actively participate in the development of a treatment plan
  - To sign forms releasing information for client information when necessary since the therapist cannot provide information without written client consent.
  - The responsibility to comply with this treatment contract and to carry out the provisions of my treatment plan

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- I understand that I may be discharged by the therapist for the following:
  - The client has completed the planned course of treatment with an acceptable degree of success
  - The client chooses to termination services
  - The therapist feels that termination is the most reasonable option, given the client's particular response to treatment
  - Other circumstances make it necessary to discontinue treatment due to hardships or impracticality, i.e. job transfer or family relocation
  - The therapist cannot provide services in a professional and ethical manner in compliance with the standards of all regulatory bodies
  - The client fails to maintain contact with the therapist for a period of more than 30 days
  - The client fails to comply with the provisions in this contract
- Repeated failure to attend scheduled appointments will result in case closure, at the discretion of the therapist
- ***Life's Light and Hope, PLLC*** is a non-smoking outpatient facility that does not tolerate violent behavior or weapons of any kind. Smokers are directed to smoke in designated ares only
- Possession and consumption of substances; including alcohol and non-prescription drugs are prohibited on the premises. Selling of illegal substances in the facility will result in contacting the police and filing charges or the illegal behavior.

- By signing this agreement I hearby agree to all provisions of the Treatment Contract and agree that I have requested the services described to me herein. I further attest that I have read my rights under the federal and state statutes for mental health services. If I have requested a copy of this information, a copy has been provided to me. I acknowledge that I have been made aware of my rights as they apply to HIPAA.
- I, the undersigned, understand that I may revoke this consent at any time except to the extent that action has been take in reliance upon it, and that in any event, this consent shall remain active until discharge from treatment at ***Life's Light and Hope, PLLC.***

INSURANCE AUTHORIZATION & ASSIGNMENT OF BENEFITS

I authorize ***Life's Light and Hope, PLLC,*** on behalf of myself and/or my dependents, to furnish medical records and other information related to health care services provided by ***Life's Light and Hope, PLLC*** to my insurance company or health maintenance organization, other payers, payer network organizations, including accountable care organizations, in which ***Life's Light and Hope, PLLC*** participates, and the contractors and third party administrators of any of these parties, as may be necessary for the payment of a bill, determination of benefits, utilization and quality review purposes, or health care operations. I hearby assign all authorized medical benefits to which I am entitles, and I request payment of all such authorized benefits be made on my

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behalf, to ***Life's Light and Hope, PLLC*** for any services furnished by ***Life's Light and Hope, PLLC.***

I authorize my insurance company or health maintenance organization, other payers, payer network organization, including accountable care organizations, and their contractors and third party administrators, to share my medical records and information obtained from ***Life's Light and Hope, PLLC***, other providers from whom I have received services, or any other payer, payer network organization, including accountable care organizations, in which ***Life's Light and Hope, PLLC*** participates, and the contractors and third party administrators of these parties, as needed for payment and health care operations.

By signing below, you acknowledge that you have read and understand the above Treatment Contract and Privacy Notice.

____

Client's signature   Date

____

Client's name   (Please Print)   DOB

____

Clinician Signature   Date

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Please indicate your preference(s) of contact (Check all that apply)

( ) Cell Telephone ……………………………………………………………………………………

( ) Work Telephone ……………………………………………………………………………………….

( ) OK to leave message with detailed information

( ) OK to text this number

( ) Leave message with call back number only

( ) OK to mail to my home address

( ) OK to mail to my work/office address

( ) OK to fax to this number ____

( ) Other: Please describe: ____

____

____

____

Client or Legal Guardian Date

____

Clinician Date