Family Outreach & Counseling Center, Inc (FOCC)

200 West Sugar Creek Rd.
Charlotte, NC 28213
Phone/Fax:704-509-9917

COUPLES THERAPY TREATMENT AGREEMENT

Please initial in each box on the left after reading the text to the right:

	FEES: The fee per 50-minute session is $150 (except for the first session, which is $200). This is due within 12/24 your session in cash, check, or credit card, unless we are billing your insurance, in which case you must pay you copayment and/or deductible at the session.
	CANCELLATION: Sessions are by appointment only. While we hate charging for missed sessions, we do reserve tha time for you. Therefore, you will be charged $75 (not just a copayment) for missed sessions or for those cancelle without 24-hour notice, except in medical emergencies. Insurance will not pay for missed sessions.
	INSURANCE: If we are a provider with your plan: We will submit claims for you, but at our session you must pa any copayment or coinsurance or any portion not covered by your plan. There may be a deductible (an amount yo will need to pay out of pocket) before your plan begins coverings sessions. If insurance does not pay as expecte you remain responsible for the balance. You have the right to waive using insurance coverage, if desired. **If We are NOT a provider for your plan:** Payment is due at each session. We can give you an invoice if you wish t seek reimbursement from your insurance. Many plans do not cover sessions with a provider who is not in the network.
	SECONDARY INSURANCE: It is your responsibility to tell me about all possible insurance plans that might cover m services (ex. if you have Medicare in addition to a secondary policy, or coverage through your work and a fami member's work). If you do not, you may be responsible in full if claims are denied.
	DIAGNOSIS: Please be aware that if you use insurance we will be required to provide a diagnosis on invoices an claims, and coverage may be limited to certain mental conditions that are covered by your plan.
	LIMITS OF MEDICAL COVERAGE: Even if you have insurance coverage for unlimited sessions, health plans ma review treatment for medical necessity, limit length of treatment or frequency of sessions, and request treatment note While we may check coverage for you, you are responsible for verifying and understanding the limits of you coverage. Although we are happy to assist your efforts in obtaining insurance reimbursement, we are unable t guarantee whether your health plan will provide payment for the services provided.
	CONFIDENTIALITY: What you say in therapy, your records, and your attendance are all confidential. Exception include when your records are subpoenaed for legal reasons, when reporting is required or allowed by law (e suspected child abuse or neglect, extreme danger to self, suspected elder abuse, or danger to others), when you giv written permission to release information, and other exceptions outlined in my *Notice of Privacy Practices.*
	WHO IS MY CLIENT? When we work with couples, we consider you both to be our client. While we may have t designate one of you as the main client on an insurance claim/invoice or treatment plan, we do not see either one of you as the source of any problems. We know that each person has their part in relationship patterns.
	INDIVIDUAL SESSIONS: During the course of our work, we may see one or both of you individually for one or more sessions. In these sessions, we will not take on the role of individual therapist -- these sessions are simply being done with the goal of furthering your couples work, unless otherwise indicated. If you feel the need for additional individual support, we are happy to refer you to an individual therapist, if needed.

	NO-SECRETS POLICY: There may be times (ex. in an individual session or an email/text) where you might want to reveal something to me that you do not want shared with your partner. However, if we are to effectively serve you as a couple, we cannot hold a secret in this way. Instead, we will urge you to discuss secrets you have shared with me with your partner. If you do not, and in my clinical judgment this secret could be negatively impacting therapy, we may feel it necessary to share it in a couple's session. Thus, if you feel it necessary to talk about topics you are unwilling to have shared with your partner, you might want to consult an individual therapist. This "no secrets" policy is intended to help me be transparent with both partners at all times, and to avoid being put a situation where we would have to end couple's treatment. *(continued)*
INITIAL BELOW	*Treatment Agreement (continued from Page 1)*
	INFORMATION/RECORDS RELEASE: One medical record is kept for the couple, where we keep all session note (whether for individual, couples, or family sessions) and significant emails, payment records, etc. If we receive request for information about treatment or for records, we would be legally and ethically required to get a writte release from both members of the couple before releasing information to anyone. This is true even for individua session notes. Exceptions to confidentiality are outlined above under "Confidentiality." If records are subpoenaed, w will always assert the psychotherapist-patient privilege on behalf of both members of the couple.
	LEGAL MATTERS: If you become involved in legal proceedings that require my participation, you agree by signin this Agreement to pay me at my regular full fee for any time we must spend on your case, including but not limited t time spent to appear in court or give depositions, and lost income for sessions we must miss.
	IN AN EMERGENCY: Leave an e-mail and voicemail message at 704-509-9917. You may also go to the emergenc room or dial 911.
	E-MAIL/SOCIAL MEDIA: In general, e-mail is the quickest way to reach us. We use e-mail to arrange/chang appointments. we do not do therapy by e-mail or video. When cancelling, please leave BOTH a voicemail and e-ma Please do not e-mail me information related to your therapy, as e-mail is not completely confidential, and importar issues should be reserved for sessions. Be aware that e-mails between us become part of your legal record. We d not accept friend requests or contact requests from clients on social networking sites (Facebook, Instagram, LinkedI etc.) out of concern for your confidentiality and my privacy. It may also blur the boundaries of our therapy relationship.
	REFERRALS/GROUP: A referral to another provider may become necessary if it becomes clear in my opinion tha your issues would be better treated by a professional with different expertise. It is unethical for me to practice beyon the level of my competence, education, training, or experience. We are not responsible for the care received fro professionals to whom we refer you. Agreements made between you and FOCC do not involve other professionals.
	ENDINGS: If you are unhappy with any aspect of therapy, please don't just leave – we ask that you talk to us to see we can work it out. Even if we can't, endings usually feel better this way. Of course, you may end therapy at any time and we are happy to assist with referrals. It is our ethical duty to provide therapy only when we feel you are active participating and benefiting from the sessions. We may end treatment if there have been repeated no-shows, late cancellations or other treatment interruptions.
	PATIENT RIGHTS: You have the right to ask any questions about your treatment or refuse to participate in treatmer at any time. This office does not discriminate in the delivery of health care services based on race, ethnicity, nationa origin, citizenship or immigration status, religion, gender, age, mental or physical disability, medical condition, sexua orientation, medical history, evidence of insurability, or source of payment.
	COMPLAINTS: The NCBLCMHC receives and responds to complaints regarding services provided within the scope o practice of therapy. You may contact the Board online at complaints@ncblcmhc.org.

	PRIVACY PRACTICES: By initialing here and signing below, you acknowledge receipt of my *Notices of Privac Practices, which* provides information about how we may use/disclose your private health information. We encourag you to read it in full. My *Notice of Privacy* Practices is subject to change. If we change my Notice, we will give you revised Notice. If you have left treatment, you may obtain the revised notice from me at the above address and phon number

PLEASE SIGN IF USING YOUR INSURANCE OR EAP: *"I authorize the release of any information necessary (Including notes, treatment summaries and diagnosis) to process claims, to prove medical necessity for treatment, to request additional sessions or to comply with treatment reviews or mandated administrative chart reviews from the insurance plan. If my therapist is a network provider, I authorize payment of benefits to be made to him/her."*

(Client #1: Sign here) :**X** _____

(Client #2: Sign here) :**X** _____

By signing below, I acknowledge that I have read and understand the above rights and policies.

X_____	**X**_____	**X**_____
Signature, Client #1	*Printed Name, Client #1*	*Date*
X_____	**X**_____	**X**_____
Signature, Client #2	*Printed Name, Client #2*	*Date*