**OFFICE POLICIES**

**CONSENT TO TREATMENT:**I understand that the frequency and type of treatment will be decided between me,and my therapist. I understand that the treatments and purpose of these procedures will be explained to me and be subject to my verbal agreement. I understand that pursuant to the release of information which I have signed, *Kari Froelicher, MA, LPC* . I understand that there is an expectation that I will benefit from psychotherapy but there is no guarantee that this will occur. I understand that maximum benefit will occur with consistent attendance and application of things learned in sessions. I also understand that at times I may feel conflicted about my therapy as the process can sometimes be uncomfortable and I may feel worse before I start to feel better.

**PAYMENT:** Payments are due at the beginning or end of each session. **I do not hold a balance on client fees**, so you will need to make sure prior to your appointment that you have your payment with you. Please notify me if any problem arises during the course of your therapy regarding your ability to make payment or of any changes well before it happens. Please notify me of any changes in your income to make adjustments to the sliding fee amount. You will be notified in writing 30 days in advance of any changes to the fee schedule. Mastercard, Visa, and Discover credit cards are accepted (this includes Health Savings Accounts with these logos). Payment with a check that is returned for insufficient funds will be charged an additional **$30 fee** to cover bank charges. If checks are returned more than once cash or credit card will be required for the duration of treatment. And of course cash is accepted.

**CANCELLATION:** It is important that you arrive on time to each session you are scheduled for. To avoid being charged for a missed session, please inform me of your cancellation **at least 24 hours** (or more) in advance. This is a courtesy so that someone else may use this time if needed. If a **true and unavoidable emergency** makes this amount of time to cancel impossible please call me **as soon** as you know that you will not be able to keep your appointment. Missed sessions not canceled with **24 hours advance notice** will be charged **$75** and will be due at the time of the next session. If you are late for a session it will not be possible to extend the length of your session.

**EMERGENCY PROCEDURES:**

If you need to contact me between sessions, please call **928-232-9280** and leave a message if I am not immediately available (this is a confidential line). I will return your call as soon as possible, but this may not be until the next business day (business days are Tuesday through Friday). If an emergency exists please call **911** and/or go to your nearest hospital emergency room. When I am out of town or otherwise unavailable for extended periods of time, a qualified professional will be available to cover for me (covering professionals may be reached by calling **928-684-0800**).

**ENDING TREATMENT:**

You have the right to end treatment at any time; however, it is recommended that there be at least **one session** prior to ending for closure and that you discuss your desire to end with the therapist before the last session. **I may also end treatment if there is a refusal to follow critical treatment recommendations or you have three canceled or missed sessions in a row.** At this time your file would be closed and you would be given access to referrals for continued care.

**I HAVE READ, UNDERSTAND AND AGREE TO THESE OFFICE POLICIES.**

Client Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dated:\_\_\_\_\_\_\_\_\_

Parent or Guardian Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dated:\_\_\_\_\_\_\_\_\_

Witness Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dated:\_\_\_\_\_\_\_\_\_