XarisCounseling

*Transforming mind, heart, life*


Wendell H. Scanterbury, Ph.D.
Marriage and Family Therapist
wendell@xariscounseling.com | www.xariscounseling.com
267.551-0360


---

## THERAPIST-CLIENT SERVICE AGREEMENT

Welcome to my practice! This document contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. Although these documents are long and sometimes complex, it is very important that you understand them. When you sign this document, it will also represent an agreement between us. We can discuss any questions you have when you sign them or at any time in the future.

PSYCHOTHERAPEUTIC SERVICES

Therapy is a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. As a client in psychotherapy, you have certain rights and responsibilities that are important for you to understand. There are also legal limitations to those rights that you should be aware of. I, as your therapist, have corresponding responsibilities to you. These rights and responsibilities are described in the following sections.

As a Marriage and Family Therapist (MFT) my goal is to advance the welfare of individuals couples and families and to make reasonable efforts to find appropriate balance between conflicting dispositions experiences and goals within the individual couple or family system.

As a member of the American Association for Marriage and Family Therapy (AAMFT) I am committed to providing professional assistance to persons without discrimination based on race, age, ethnicity, socioeconomic status, disability, gender, health status,

religion, national origin, sexual orientation, gender identity, relationship status, or other personal distinctive. If for any reason I feel as a therapist that I am unable to provide you with the best care possible, I will discuss this with you and make every effort to provide a referral to another therapist who is better equipped to serve you more effectively. I ask that if you feel you are not receiving the care that you need and deserve, you bring this to my attention so that we can collaboratively address your concerns for your best outcomes.

CONFLICTS OF INTEREST

I am obligated to guard against any conflicts of interest (i.e. personal benefits resulting from my professional work or disposition) that may arise as a result of the therapist-client relationship. This will include, but is not limited to, business or close personal relationships beyond our therapeutic relationship. I will avoid such relationships to the fullest extent possible so as to minimize the risk of impaired professional judgment or the exploitation of our therapeutic relationship. I ask you to do the same by bringing any concerns you may have to my attention so we can discuss it openly and come to a mutual and respectable consensus.

THERAPY SESSIONS

Psychotherapy has both benefits and risks. Risks may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness, because the process of psychotherapy often requires discussing the unpleasant aspects of your life. However, psychotherapy has been shown to have benefits for individuals who undertake it. Therapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems. But there are no guarantees about what will happen. *Psychotherapy requires a very active effort on your part. In order to be most successful, you will have to work on things we discuss outside of sessions.*

The first two to four sessions will involve a comprehensive evaluation of your needs. By the end of the evaluation, I will be able to offer you some initial impressions of what our work might include. At that point, we will discuss your treatment goals and create an initial treatment plan. You should evaluate this information and make your own assessment about whether you feel comfortable working with me. Therapy involves a commitment of time, money, thought, and energy; so, you should be very careful about the process of determining the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion with your consent.

APPOINTMENTS

Appointments will ordinarily be 45-50 minutes in duration, once per week at a time we agree on, although some sessions may be more or less frequent as needed. The time scheduled for your appointment is assigned to you and you alone. **If you need to cancel or reschedule a session, I ask that you provide me with 24 hours'**

**advance notice.** If you miss a session *without canceling (no-show), or cancel with less than 24-hour notice (late cancellation)*, my policy is to assess a $50 fee [unless we both agree that you were unable to attend due to circumstances beyond your control]. If it is possible, I will try to find another time to reschedule the appointment. In addition, you are responsible for coming to your session on time; if you are late, your appointment will still need to end on time.

PROFESSIONAL FEES

The fees for my services are published on my website or available on request. The fee is fixed by mutual agreement at the initial session. You will be invoiced for your session unless prior arrangements have been made. Payment may be made using debit or credit card. Subsequent sessions will not proceed while your session fee remains outstanding. If you refuse to pay your debt, I reserve the right to use an attorney or collection agency to secure payment. If you are experiencing financial hardship, I ask that you make me aware so that we can discuss potential options for the billing and provision of services. Fees may be adjusted from time to time, but not prior to informing clients in advance of upcoming changes and affording clients the opportunity to determine their willingness to accept the adjustments.

ADDITIONAL SERVICES

In addition to therapy appointments it is my practice to charge for other professional services that you may require such as report writing, telephone conversations that last longer than 15 minutes, attendance at meetings or consultations which you have requested, or the time required to perform any other service which you may request of me. My full fee will apply on a prorated basis (I will break down the hourly cost). **If you anticipate becoming involved in a court case, I recommend that we discuss this fully before you waive your right to confidentiality.** If your case requires my participation, you will be expected to pay for the professional time required even if another party compels me to testify. Because of the difficulty of legal involvement, my fee for preparation and attendance at any legal proceeding begins at $200 per hour.

If your account has not been paid for more than 60 days and arrangements for payment have not been made, I reserve the option of using legal means to secure payment for services. This may involve hiring a collection agency or entering small claims court. If such legal action becomes necessary, costs will be included in the claim. In most collection situations the only information I release regarding a patient's treatment is his/her name the nature of services provided and the amount due.

INSURANCE

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. **I am not a member of insurance panels and therefore do not bill insurance carriers for payment for therapy services.** You will therefore be fully responsible for all fees for the services provided.

PROFESSIONAL RECORDS

I am required by the laws and standards of my profession to keep appropriate records of the psychotherapeutic services that I provide. Your records are maintained in a

secure location in the office. I keep brief records noting that you were here, your reasons for seeking therapy, the goals and progress we set for treatment, your diagnosis, topics we discussed, your medical, social, and treatment history, records I receive from other providers, copies of records I send to others, and your billing records. Except in unusual circumstances that involve danger to yourself, you have the right to a copy of your file. Because these are professional records, they may be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them with me, or have them forwarded to another mental health professional to discuss the contents. If I refuse your request for access to your records, you have a right to have my decision reviewed by another mental health professional, which I will discuss with you upon your request. You also have the right to request that a copy of your file be made available to any other health care provider at your written request.

CONFIDENTIALITY

My policies about confidentiality, as well as other information about your privacy rights, are fully described in a separate document entitled *Notice of Privacy Practices*. You have been provided with a copy of that document and we have discussed those issues. Please remember that you may reopen the conversation at any time during our work together.

PARENTS & MINORS

While privacy in therapy is crucial to successful progress, parental involvement can also be essential. It is my policy not to provide treatment to a child under age 13 unless s/he agrees that I can share whatever information I consider necessary with a parent. For children 14 and older, I request an agreement between the client and the parents allowing me to share general information about treatment progress and attendance, as well as a treatment summary upon completion of therapy. All other communication will require the child's agreement, unless I feel there is a safety concern (see also above section on Confidentiality for exceptions), in which case I will make every effort to notify the child of my intention to disclose information ahead of time and make every effort to handle any objections that are raised.

CONTACTING ME:

I am often not immediately available by telephone. I do not answer my phone when I am with clients or otherwise unavailable. At these times, you may leave a message on my confidential voice mail and your call will be returned as soon as possible. If, for any number of unseen reasons, you do not hear from me or I am unable to reach you, and you feel you cannot wait for a return call or if you feel unable to keep yourself safe, 1) contact Montgomery County Peer Support Talk Line at **1-855-634-HOPE (4673)**. Alternatively, in Philadelphia, please contact the Crisis Intervention Hotline at **215-686-4420**, or 2) go to your Local Hospital Emergency Room, or 3) call 911 and ask to speak to the mental health worker on call. I will make every attempt to inform you in advance of planned absences and provide you with the name and phone number of any mental health professional covering my practice.

OTHER RIGHTS

If you are unhappy with what is happening in therapy, I hope you will talk with me so

that I can respond to your concerns. Your concerns will be taken seriously and handled with care and respect. You may also request that I refer you to another therapist and are free to end therapy at any time. You have the right to considerate, safe and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment. You have the right to ask questions about any aspects of therapy and about my specific training and experience. You have the right to expect that I will not have social or sexual relationships with clients or with former clients.

**CONSENT TO PSYCHOTHERAPY**

Your signature below indicates that you have read this Agreement and the Notice of Privacy Practices and agree to their terms.

| Client/Responsible Adult Printed Name(s) and Relationship to Client (if not Self) | Signature | Date |
|---|---|---|
| ______________________________ | ______________________________ | ________________ |
| ______________________________ | ______________________________ | ________________ |
| ______________________________ | ______________________________ | ________________ |
| ______________________________ | ______________________________ | ________________ |
| ______________________________ | ______________________________ | ________________ |
| ______________________________ | ______________________________ | ________________ |
| ______________________________ | ______________________________ | ________________ |

| Therapist | Signature | Date |
|---|---|---|
| Wendell Scanterbury, Ph.D. | ______________________________ | ______________ |