Tree of Life Counseling Services, LLC

Arcturus Patients

Main Office
145 Rochdale Dr S.
Suite F
Rochester Hills, 48309

WellPointe Office
1701 South Blvd.
Suite 240
Rochester Hills, 48307

Troy Internal Medicine
4967 Crooks Rd.
Suite 110
Troy, 48098

SERVICES CONTRACT

Welcome to the office of Tree of Life Counseling Services, LLC. This document contains important information about my professional services and business policies. It is important that you read this document carefully and present any questions that you have during our first session. Signing this document means that there is a binding agreement between you and I.

ASSUMPTIONS OF RISKS

Therapy sessions carry both benefits and risks. Therapy sessions can significantly reduce the amount of distress someone is feeling, improve relationships, and/or resolve other specific issues. However, these improvements and any "cures" cannot be guaranteed for any condition due to the many variables that affect these therapy sessions. Experiencing uncomfortable feelings, discussing unpleasant situations and/or aspects of your life are considered risks of therapy sessions.

Because of the nature of counseling it involves both benefits and risks. Some of the benefits include better functioning in various areas of living, finding solutions to specific issues and a decrease in negative feelings, thoughts and behaviors. However, it does have some risks because you often will discuss unpleasant memories and related feelings.

COUNSELING SERVICES

I provide professional counseling services to adolescents, adults, couples and families. Counseling is "a professional relationship that empowers diverse individuals, families and groups to accomplish mental health, wellness, education, and career goals".

CREDENTIALS

I am a clinical mental health intern.

SESSIONS

For adult, family and group counseling, the initial evaluation time can range from between 1-3 sessions. These sessions may range from 45-60 minutes. All subsequent sessions will be 45 minutes.

For adolescent counseling, during the initial evaluation I will meet with the parent(s) and the minor to discuss the specifics and magnitude of the issue. I subsequently, will meet with the minor individually and the parent as needed either the first 10 minutes of the session or the last 10 minutes of the session. Child and adolescent sessions will range from 30-45 minutes depending on the age and developmental stage of the adolescent. If counseling is initiated, I will schedule one forty-five-minute session per week at a mutually agreed upon time. As part of my services, understandably we will have telephone communications, however, communications via telephone that extend beyond scheduling will be designated as a session and will be prorated based on my normal fees. These fees will be due at the time of your next scheduled in-office appointment. In an effort to maintain confidentiality, communication via Internet is not utilized with the exception of scheduling via email.

CANCELLATION POLICY

You are responsible for payment of a scheduled appointment unless you provide 24 hours advance notice of cancellation, unless unforeseen emergencies arise. Appointments cancelled with less than 24-hour notice, will be subject to a $30.00 late cancellation fee. Patients who do not show up for their appointment without notice of cancellation will be considered as NO SHOW and will also be subject to a $30.00 fee.

BILLING AND PAYMENT

At the time of service, you are responsible for payment. I accept personal checks, cash, money orders and credit card.

MINORS

If you are under 18 years of age, the law provides your parent(s) with access to your record. However, in an effort to strengthen the therapeutic relationship I encourage parent(s) /guardians to waive this right and discuss pertinent information as a group during the first or last ten minutes of sessions as needed.

CONFIDENTIALITY

Without the **written consent** of the client or their legal representative I am obligated to maintain confidentiality. However, I am obligated to break confidentiality under certain circumstances which includes:

- **Harm to yourself**: If I believe that you are threatening harm to yourself I am legally obligated to report this. This means that I am required to take actions to protect you such as requiring hospitalization or seeking assistance from loved ones or law enforcement.

- **Harm to others**: If I believe you are threatening serious harm to others I am legally obligated to report this. I have a duty warn the individual(s) who you are threatening, notify law enforcement and seek assistance or hospitalization for you.
- **Harm to minors or individuals who are mentally, emotionally or physically impaired**: If I believe that you are threatening harm to individuals who have a disability I am legally required to report it to the appropriate state agency
- **Harm to the elderly**: If I believe that you are threatening harm to an individual who is elderly I am legally required to report it to the appropriate state agency.
- **If I am required to by court order.**
- By signing this contract, you are entering into a binding agreement with Brian Bishop. By signing this agreement, you are acknowledging that you understand and agree to abide by its terms.

_____	_____
DATE	CLIENT
_____	_____
DATE	PARENT/GUARDIAN (If Client is a minor)
_____	_____
DATE	PARENT/GUARDIAN (If Client is a minor)
_____	_____
DATE	COUNSELOR