STAR Counseling & Consultation, PLLC

APPOINTMENTS

The therapy session will be 45-55-minute session (one appointment hour). **Once an appointment hour is scheduled, you will be expected to pay for a late cancellation unless you provide 24 hours advance notice of cancellation [unless we both agree that you were unable to attend due to circumstances beyond your control].**

You will be responsible for 50% of the fee for the first missed appointment and 100% of the fee for any subsequent missed appointments. If this is a continuing pattern, your care may be discontinued and I would provide you with referrals to other mental health clinics.

I make every effort to make reminder calls, texts, or email if you give me permission and provide the valid information. However, reminder calls are a **courtesy**. I am not responsible in the event that you do not receive your reminder call, text, or email for any reason. Not receiving a reminder call regarding an appointment **does not** absolve your responsibility in terms of our missed appointment / no show policy.

The client is responsible for contacting the office with any changes in phone numbers, addresses, and legal issues pertaining to minor children.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE RECEIVED THIS AGREEMENT AND READ THIS AGREEMENT AND ARE CONSENTING TO TREATMENT WITH STAR Counseling & Consultation, PLLC. IT ALSO INDICATES THAT YOU AGREE TO THE TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

We require any one 14 and older to sign this agreement. For all minors, 18 and younger, a parent/guardian must also sign.

____ _________________________

Signature of Client Date

____ _________________________

Minor Signature of Parent/Guardian Date

________ Therapist initials

STAR Counseling & Consultation, PLLC

INFORMED CONSENT/WAIVER FOR NON-COVERED, NON-THERAPY, OR UNUSUAL SERVICES

We would like you to know that there are additional fees for some services and we would like you to be aware of our policies regarding these services. We will not release any information without proper signed releases of information from all parties involved in therapy. We may also request that you sign a separate consent for certain specific services.

Some specific examples of non-covered services include but *are not* limited to:

Preparation for any services requested in regard to litigation
Testimony in court and time spent waiting to testify or present requested information.
Deposition for any litigation
Reports in regard to any litigation
Any services in response or regard to litigation
Any fees associated with protecting your medical record including but not limited to:
Filing a motion to quash a subpoena
Letters (to attorney, school, law enforcement, DHS and others)
Reports (conciliation, school, etc.)
Meeting with attorneys and others
Associated travel for any non-covered services
School staffings, meetings with teachers and other school personnel, etc.
Specific phone consultations that do not include therapy
Requested medical records, summaries, reports, etc.
Time blocked out for anything on this list (even if it is cancelled within 24 hours)

I understand that I will be billed for the therapist's time and I acknowledge responsibility for paying for these services in full.

____ ____________________________
Signature of client or guardian Date signed

Print client name:____

________ Therapist initials

STAR Counseling & Consultation, PLLC

PAYMENT

I request that the clinician named below provide professional services to me or to _________________, who is my ________________________ and I agree to pay this clinician's fee of $_______ per session for these services or the fee of $____ for _______________________.

I understand that there are different and additional fees for non-therapy or unusual services includes in the addendum separate from the agreed upon prices listed above.

I understand and agree that I am responsible to pay the charges for services provided by this clinician to me (or this client), although other persons may make payments on my (or this client's) account.

____***Insurance or Sondermind referral clients:*** If paying with insurance, payment will be made thru the Sondermind portal.

____***Direct Clients (non Sondermind referrals):*** Payment may be made by check, cash, Paypal or Venmo.

I agree to pay for services provided to me (or this client) up until the time we end the relationship. We will discuss ending, and a date will be agreed to and recorded in this client's medical records; or I will inform the clinician, in person or by writing that I wish to end it.

____ ____/____/____

Signature of client (or person acting for client) Date

____

Printed name of client (or person acting for client)

I, the clinician, have discussed the issues above with the client (and/or the person legally acting for the client). My observations of the person's behavior and responses give me no reason to believe that this person is not fully competent and able to give informed and willing consent.

____ ____/____/____

Signature of clinician Date

❑ *Copy accepted by client or* ❑ *Copy kept by clinician*

Venmo: *@Sarah-Howell-109*
Paypal: *paypal.me/skhowelllcsw Sarah Howell*
Checks*: payable to: Sarah Howell*