Smith & Associates Mental Health

Therapy Agreement

I understand that therapy sessions for me and/or my children are strictly confidential with the following exceptions:

- My therapist must honor court subpoenas that require the release of specified information.
- My therapist may take professional action to protect those in immediate danger of physical harm.
- My therapist is mandated by Florida law to report suspected child or elder abuse or neglect.
- My therapist may share information with me from my children's therapy sessions if he or she believes that my children are in imminent danger.

Email and texts are not secure (encrypted) forms of communication. If I initiate their use for scheduling or updating appointments, my therapist will follow suit; however, he or she will not use them for communicating about personal matters.

I understand that my therapist is not available 24 hours a day and that in a crisis situation I should call First Call for Help (954) 537-0211, the Henderson Crisis Walk-in Center or Mobile Crisis Response Team (954-463-0911), or 911.

I agree to notify my therapist at least 24 hours in advance should I need to cancel an appointment. If I fail to do so, I understand that I will be charged a for the full session as a late cancelation fee, payable at or before my next appointment.

I understand that if my therapist is asked or required to provide a summary of my records, he or she will charge a minimum of his or her one-hour fee, which must be paid prior to the records being sent.

I understand that the fee for service is $150 for a 45-minute session or $50/quarter hour. The same fee (prorated) is charged for between-session telephone consultations lasting longer than five minutes.

Providing accurate, valid and complete information about yourself and your insurance
If I fail to provide valid and accurate insurance information that results in the insurance company denying payment, all outstanding fees will be billed to my account. To avoid this situation I will inform the office manager or therapist of cancellations or changes in my insurance as soon as possible.

Honoring your co-payment agreement
All deductible amounts and co-payments are determined by your insurance carrier and are **due for payment at the time services are rendered.** Obligation and co-payments will vary depending on health insurance contracts. Rates may be adjusted according to particular insurance company contracts and individual needs.

Direct payment for services rendered
Initial evaluation is $250. For continued 45-50 minute psychotherapy sessions the fee is $150.00. If we have no contract with your insurance or you simply choose not to use your benefits for psychotherapy a mutually acceptable fee will be agreed upon between you and your therapist.

Missed appointments, without a 24 hour notice will be billed.
Because time has been reserved exclusively for me and /or my family member(s), I understand that I am required to provide at least a 24 hour advance notice if unable to keep the scheduled appointment.

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Therefore, I understand that "no show" appointments will be billed at the rate of $125.00. Same day cancellations are also subject to be billed. Decision is at the discretion of the therapist. Insurances are not billed for missed appointments. Non-payment of fees can result in termination of services and referral to another provider.

I have read and understand my financial responsibilities. My signature below indicates that I will accept full responsibility for any fees billed to my account.

_____	_____	_____
Name	Signature	Date
_____	_____	_____
Name	Signature	Date