# Glenda Rosenberg, M.Ed. L.P.C.

## WORKING RELATIONSHIP AGREEMENT

*Please fill out the following information:*

Name: _____ Date of Birth: _____

Address:_____

Phone: Cell_____ Home_____Work_____
May I leave messages at the above numbers? Yes / No

### ____Appointments

Individual appointments are 60 minutes in length. I schedule appointments at a frequency that is best for you and your situation.

### ____Cancellations

There is no charge for appointments cancelled or changed at least 24 hours in advance. With shorter notice, you are agreeing to pay for the time you reserved, and you will be billed for a full session. Notify me of your cancellation or rescheduling needs by leaving a voicemail.

### ____Fees and Payments

Payment for services is due at the end of each session. Fees may change over time, but you will be informed of any potential rate increases well in advance. My charge is $90.00 per hour.
Fees will be collected in cash or by check. Please make all checks payable to Glenda Rosenberg..

### ____Insurance

I do not accept insurance, but will provide you with a monthly statement that includes all of the information you may need to file with your insurance company for reimbursement. If you have any questions as to whether or not your sessions will be covered, you should contact your insurance company directly to obtain their policies and procedures.

### ____Emergencies

If you need to contact me between sessions, please leave a message on my voicemail and your call will be returned as soon as possible. I check messages regularly during the week and less frequently on weekends and holidays. If an emergency situation arises, please indicate it clearly in your message. If you are experiencing a clinical emergency and are unable to reach me, please call the emergency hotline at 472-HELP, call 911, or go directly to your nearest emergency room.

## ____Confidentiality

All interactions with me including scheduling of appointments, your records, content of your sessions, and progress in counseling are kept confidential. There are some exceptions to confidentiality as dictated by the law**.** Please discuss with me any questions or concerns you may have regarding confidentiality.

## ____Litigation Limitation

Due to the nature of the therapeutic process and the fact that it often involves clients making full disclosure with regard to many matters that may be of a confidential nature, it is agreed that should there be legal proceedings (such as but not limited to, divorce and custody disputes, injuries, lawsuits, etc.), neither you, the client, nor your attorney, nor anyone else acting on your behalf will call on me to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested.

## ____Our Agreement

Services are designed to meet your individual needs and will be tailored to the goals developed in the therapeutic process. I encourage you at any time to discuss with me any feelings, concerns, or thoughts regarding the methods and policies of your therapy.

***I have read and understand the above information and, as the party responsible for payment, agree to these conditions:***

_____

Client Printed Name

_____ _____

Client Signature Date

_____ _____

Therapist Signature Date