Positive Mind Therapy

Financial Fees and Consent for Mental/Behavioral Health Therapy

Client Name:

Birthdate:

Email:

Check which phone numbers are okay to call:

☐Cell #: ☐Check box if I can I leave a message

☐Home #: ☐ Check box if I can I leave a message

Who recommended PMT?

I want my referral source to know client is attending PMT. ☐Yes ☐No

Treatment Plan: Main Concerns and Goals for Counseling: Click here to enter text.

Financial Agreement *(Please READ CAREFULLY)*

I agree to be financially responsible for all treatment costs. I agree to give at least ***24 hour notice*** if I cannot attend a scheduled appointment and agree to the following (you will be notified in advance if *rates change). If I refuse or fail to honor these agreements, PMT has the right to release my account, demographic and billing information to a collection service, and* I *agree to cover any related collection fees (40-50% of balance is typically charged; additional small claims court fees may also be assessed) and understand my treatment/services may be terminated.*

PMT FEES:

Initial Assessment (45-50 minutes): $195

Individual Therapy or Teletherapy (45-50 minutes): $195

Group Therapy (45-50 minutes): $97.50

Group Parenting Classes (90 minutes/class): $97.50 for 1st parent or $117.50 for both parents + (One free book per family included)
(The Systematic Training for Effective Parenting class runs 90 minutes, once a week for 6 weeks total. Each session builds on the previous session. Half of the class payment is due by the beginning of session 1 for the first three sessions and session 4 for the last three sessions. Example: One parent = $292.50 by session 1 and $292.50 by session 4 or use discount below)
Discount Available: As an incentive to you to benefit from the entire Parenting Class Training, I will deduct $97.50 off the 6 week classes: Pay half of the class payment ($292.50) by the beginning of session 1 for the first three sessions and the second half ($195) is due by session 4 for the last three sessions.

Private Parenting Classes (Description is the same as Group Parenting Classes though the fees are $195 per 90-minute class.) **Discount available for all 6 sessions as stated in Group Parenting Classes section above. Your deduction will be $195.**

Other rates may apply for Telephone Consultation, Requested Reports, Lengthy Emails, School Meetings, Written Correspondence or other services.

Bounced Check: **$30**

No Show or Late Cancel (less than 24 hours): 1st time 25%, 2nd time 50%, 3rd time full session cost. If you miss an appointment, this prevents other clients from being seen and PMT has to cover office expenses. Thank you for being understanding and responsible.

Consents

I consent to private or clinical information sent to me via: ☐TEXT MESSAGES; ☐VOICEMAIL / MESSAGES; ☐US MAIL Click here to enter text.

Signature

I consent to using Telephone and/or Video technology if I choose to receive services away from PMT Click here to enter text.

Signature

I agree to pay the fee for any missed, no-show or late-canceled appointments:
Click here to enter text.
Signature

I understand my treatment may be considered "closed / discharged" 30 days beyond last visit w/o expressed intent to continue. Records will be kept in locked file cabinet at therapist's home office. Records will be emailed to client upon written request. Unclaimed records from closed /discharged clients will be shredded after 6 years.
Click here to enter text.
Signature

I understand that my treatment records & clinical information will be kept confidential and that information about my involvement here will not be released outside PMT without my authorization, except as outlined below under "EXCEPTIONAL SITUATIONS"; laws and/or ethical guidelines may mandate this reporting to *law enforcement and/or Dept. of Child Services.*

The treatment may include billing information with on or off-site contracted *office staff,* or *collection agency*.

EXCEPTIONAL SITUATIONS *in which my clinical and other information might be shared and/or NOT kept confidential:*

- **A human life is potentially in great danger, such as someone intending to complete suicide or seriously harm someone else.**
- **A child (or handicapped adult) is suspected of being in danger of being or having been abused or neglected physically, sexually, or psychologically.**

- **I sign a consent form giving this clinic/staff my permission to share information about me, or to request information about me. (I can cancel any signed consent any time prior to the expiration).**
- **A court order or subpoena is issued.**
- **I fail to honor my financial obligations for services received.**
- **In my therapist's professional group or individual supervision. No names will be shared.**

If you have any questions, please ask prior to signing this form.

If there is any emergency, please call 911, go to the Emergency Room or call the Maricopa County Crisis Line (602-222-9444). PMT does not have the capability to respond immediately to emergencies.

X _____ X _____

Client or Parent/Guardian if under 18 Date