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.*

FEES:

Initial Assessment *(45-50 minutes): $185*

Individual Therapy or Teletherapy *(45-50 minutes): $185*

Group Therapy *(45-50 minutes): $92.50*

Group Parenting Classes *(90 minutes/class): $92.50 per class for 1st parent + $20 per class extra for 2nd parent/relative billed each session. There are a total of 6 classes, once/week. (One free book per family is included.)* The Systematic Training for Effective Parenting class builds on the previous class.

Discount Available as an incentive to you to benefit from the entire Parenting Class Training, I will deduct $92.50: Option 1 -Pay in full ($555). Option 2- Pay half of the class payment ($370) by the beginning of session 1 for the first three sessions **and** the second half ($185) is due by session 4 for the last three sessions. The extra parent/relative fee will be charged each week only when there is an extra person.

Private Parenting Classes *(Description is similar to the Group Parenting Classes though the fees are $185 per 90 minute class for the 1st parent + $20 per class extra for 2nd parent/relative. One free book per family is included.)*

Discount Available as an incentive to you to benefit from the entire Parenting Class Training, I will deduct $185.00: Option 1 -Pay in full ($925). Option 2- Pay half of the class payment ($555) by the beginning of session 1 for the first three sessions **and** the second half ($370) is due by session 4 for the last three sessions. The extra parent/relative fee will be charged each week only when there is an extra person.

Other rates may apply to Telephone Consultation, Requested Reports, Email, 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-showed 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