

Marriage & Family Therapy

Congratulations on initiating a commitment to make changes toward your personal growth and mental well-being. Thank you for choosing professional counseling services at Zem Therapy & Consulting LLC. We understand that initiating counseling services is a major decision that comes with many questions. This document is intended to inform you of our policies, as well as standards relevant to State and Federal Laws.

Please review each section below and feel free to ask any questions.

Counseling Consent and Client Commitment

I grant permission and give consent to _____ Zem Therapy & Consulting LLC to provide therapy and counseling services to me and/or my child. I understand that this counselor is not providing an emergency service and is not immediately available/on call during non-office hours. In case of an emergency, I agree and understand my need to seek assistance from my local hospital/emergency room or police department.

Attendance

Each counseling session is scheduled for approximately 45-50 minutes.

- I understand that it is my responsibility to attend sessions as scheduled.
- If I have to cancel a scheduled session, I will give a 24 hour advance notice to this counselor.
- If I do not attend a scheduled session and fail to notify this counselor, I agree to pay a missed session fee of \$25.00, which I understand is not able to be submitted to insurance.
- If I miss a scheduled session it is my responsibility to call and reschedule.

Confidentiality and Notice of Receipt of Privacy Practices

- I understand the content of sessions will be kept confidential, except where identified legal limitations apply or with written consent.
- I have been informed of the legal limitations exceptions to confidentiality which includes but is not limited to danger to myself, danger to others or any form of child abuse or neglect.
- I have been informed of my rights to privacy according to a read copy of Zem Therapy & Consulting LLC Notice of Privacy Practices. I understand my rights as outlined in the Notice of Privacy Practices, as well as the legal limitations/ exceptions to confidentiality. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Zem Therapy & Consulting.
- I understand I will have to sign a Standard Release of Information Authorization Form prior to any information concerning myself or my children can be released to any other party including, but not limited to any insurance company.
- In the unlikely or unfortunate event that Zem Therapy & Consulting is unable to provide ongoing services, we will refer you to appropriate resources. Your records will be maintained for a period of 7 years at Zem Therapy & Consulting 708-414-6842.

Financial Requirement

- I agree to pay an initial assessment session fee of \$150 and the established fee of \$150 per session due at the time of each session.
- If I utilize insurance company, I understand I am responsible to pay the full fees due at the time of services until my deductible is satisfied and thereafter, I understand that I am responsible to pay the co-payment/percentage of fee not covered at the time of service.
- I understand I am officially responsible for any portion of the fees denied by the insurance company and I agree to pay the remaining balance in full.
- In the event that I am negligent of my account for 60 days, I agree to pay 1.5% interest a month (18%APR) on the unpaid balance and in the event that an account is negligent for 120 days and is turned over to our collection agency. I agree to any fee charged by collections to requisite the debt owed.

I understand all of the obligations listed above, I am in agreement with established commitments and I agree to participate voluntarily.

Name of Client: _____ Client Date of Birth: _____

Name of Client: _____ Client Date of Birth: _____

Name of Parent/Legal Representative if Client is a Minor: _____

Relationship to minor: _____

Signature: _____ Date: _____

Counselor Signature: _____