Thank you for choosing Awaken Grace Counseling as a potential ally to help you with your challenges. I look forward to working with you.

* Would you please be sure to upload to the profile, a copy of your insurance card, front and back and your photo ID. If you have already done so, I thank you. Each session paid for by insurance will be 55 minutes long. If private pay, it will be 60 minutes.

* If you are using your EAP Benefits for Counseling, Please be advised that your session will be 45 minute long.
Please be sure to let us know, and let your company know to send us a copy of your authorization to Fax 855-744-8767.

* Let us know if you have any questions about the consent forms and mental health surveys in the documents and forms tab.

* Please read this important information about our professional services and business policies.

PRACTICE POLICIES
APPOINTMENTS AND CANCELLATIONS
You may contact the office via phone, email or text Monday-Sunday 10am- 6pm for cancellations, rescheduling or to contact your therapist. 314-578-3551 is the best number to text. The patient portal also gives you options for appointment changes and contacting the office.
Please remember to cancel and/or reschedule at least 24 hours in advance. If less then 24 hours cancellation you will be charged $88.
If you are late for your session, the appointment time will not be extended.
If you are 15 minutes late for your session, you will be considered a no show.
No Shows will be charged the cancellation fee.
Credit card required on file prior to booking.
A credit card is required to be on file for copay, coinsurance fees and/or late cancel or no-show fees.

Appointments will not be reserved/confirmed without this.
Fees are due at time of service and no balance will be carried past 15 calendar days. Appointments will hold until the account is current.

TELEPHONE ACCESSIBILITY
If you need to contact me between sessions, please leave a message on my voicemail, or text. I am often not immediately available; however, I will attempt to return your call within 24 hours. Please note that Face- to-face sessions are highly preferable to phone sessions. However, in the event that you are having technical difficulties, phone sessions are available.
Non-emergent Issues:
You are encouraged to wait until your next scheduled session. Writing things down can be helpful for both remembering what you wanted to discuss as well as for containment.

SOCIAL MEDIA AND TELECOMMUNICATION
Due to the importance of your confidentiality and the importance of minimizing dual relationships, I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, Instagram etc.). I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet and we can talk more about it

ELECTRONIC COMMUNICATION
There is no audio or video recording of sessions of any kind without written permission from your provider. Technology based communications (cell phone, email, fax) have privacy and confidentiality limitations, unless encrypted. We do not regularly use encrypted services, so our calls and emails are non-secure. Please let us know, if for your privacy you do not want to be contacted by phone or email. See the consent for transmission of protected health information by non-secure means to give or revoke consent. If we have an email and/or cell phone you may receive appointment reminders, but you can unsubscribe any time.
Urgent Issues
Issues requiring immediate assistance

RELATED TO SAFETY: This office does not have a specific crisis line and asks clients to work the steps in their collaboratively constructed crisis plan that includes contacting a crisis line for safety concerns. If you do not have a specific crisis plan, please use the crisis line numbers for support. Please see numbers below for reference. Emergencies: If you need assistance for safety issues that require speaking to someone immediately call 911 or go to the nearest hospital.
Hotline (crisis line run by trained individuals)
MOCSA (sexual trauma) 816-531-0233 or 913-642-0233 National Domestic Violence Hotline 800-799-SAFE Rape, Abuse & Incest National Network (RAINN) 800-656-HOPE National Suicide & Crises Lifeline 988 Alternatives (Self Injury) 800-366-8288

TERMINATION

Ending relationships can be difficult. Therefore, it is important to have a termination process in order to achieve some closure. The appropriate length of the termination depends on the length and intensity of the treatment. I may terminate treatment after appropriate discussion with you and a termination process if I determine that the psychotherapy is not being effectively used or if you are in default on payment. I will not terminate the therapeutic relationship without first discussing and exploring the reasons and purpose of terminating. If therapy is terminated for any reason or you request another therapist, I will provide you with a list of qualified psychotherapists to treat you. You may also choose someone on your own or from another referral source.
Should you fail to schedule an appointment for 4 consecutive weeks, unless other arrangements have been made in advance, for legal and ethical reasons, I must consider the professional relationship discontinued.

I. PSYCHOLOGICAL SERVICES
Therapy is a relationship between people that works in part because of clearly defined rights and responsibilities held by each party. As a client in psychotherapy, you have certain rights and responsibilities. There are also legal limitations to those rights you should be aware of. As your therapist, I have responsibilities to you, as well. These rights and responsibilities are described in the following sections.

Psychotherapy has both benefits and risks. Risks may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness, because the process of psychotherapy often requires discussing unpleasant aspects of your life. However, psychotherapy has been shown to have benefits for individuals who undertake it. Therapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems. But, there are no guarantees about what will happen. Psychotherapy requires a very active effort on your part. In order to be most successful, you will have to work on things we discuss outside of sessions.

The first 2-4 sessions will involve a comprehensive evaluation of your needs. By the end of the evaluation, I will be able to offer some initial impressions of what our work might include. At that point, we will discuss your treatment goals and create an initial treatment plan. You should evaluate this information and make your own assessment about whether you feel comfortable working with me. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

III. PROFESSIONAL FEES
The standard fee for a 60 minute session is 173.00. Insurance pays for 55 minutes and EAP pays for 45 minutes. You are responsible for paying at the time of your session unless prior arrangements were made, such as process an insurance claim, in which case any copay is due at the time of service. This is the reason for the card on file. In our ongoing commitment to ensuring the security and confidentiality of your sensitive information,
card information is not saved or stored on our internal servers or databases. We do not have access to your numbers or information.
We use an Insured and Bonded third party credit card processor, Cayan Inc. Our commitment is to provide you
with a hassle-free and secure experience when managing your recurring payments.
By signing this form, you authorize charges to your credit card through Therapy Appointment for services rendered. These charges will appear on your bank/credit card statement as Awaken Grace LLC. You have the right to request a paper copy of this document.

I authorize Awaken Grace LLC to charge my credit card through Therapy Appointment.

 I agree that my credit card can be charged $88 for any session not canceled at least 24 hours prior to the scheduled session.

**This authorization will remain in effect until canceled in writing, and I
agree to notify Therapy Appointment in writing of any changes in my account information or termination of this authorization

 I certify that I am an authorized user of this credit card and will not dispute these scheduled transactions with my bank or Credit Card Company as long as the transactions correspond to the terms indicated in this authorization form.

 I acknowledge that credit card transactions could be linked to Protected Health Information

**Any declined debit or credit charge returned to my office are subject to an additional fee of up to 25.00.

In addition to weekly appointments, it is my practice to charge this amount on a prorated basis (I will break down the hourly cost) for other professional services that you may require such as report writing, telephone conversations that last longer than 15 minutes, attendance at meetings or consultations which you have requested, or the time required to perform any other service which you may request.

If you anticipate becoming involved in a court case, I recommend that we discuss this fully before you waive your right to confidentiality. If your case requires my participation, you will be expected to pay for the professional time required even if another party compels me to testify.

IV. INSURANCE
You are responsible for knowing your coverage and for letting me know if/when your coverage changes. A copy of your insurance card front and back along with a copy of your photo Id will be required in order for me to file a claim with your insurance. You may upload a confidential copy via this portal upon registration.

If you plan to use your insurance, authorization from the insurance company may be required before they will cover therapy fees. If you did not obtain authorization and it is required, you may be responsible for full $173.00 payment of the fee.

You are well advised to contact your insurance company to inquire as to your out of pocket expenses and coverage.

Once you have all of the information about your insurance coverage, we will discuss what we can reasonably expect to accomplish with the benefits available and what will happen if coverage ends before you feel ready to end your sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above, unless prohibited by my provider contract.

If I am not a participating provider for your insurance plan, I will supply you with a receipt of payment for services, which you can submit to your insurance company for reimbursement. Please note that not all insurance companies reimburse for out-of-network providers. If you prefer to use a participating provider, I will refer you to a colleague.

V. PROFESSIONAL RECORDS
I am required to keep appropriate records of the psychological services that I provide. Your records are maintained in a secure location in the office. I keep brief records noting that you were here, your reasons for seeking therapy, the goals and progress we set for treatment, your diagnosis, topics we discussed, your medical, social, and treatment history, records I receive from other providers, copies of records I send to others, and your billing records.

Except in unusual circumstances that involve danger to yourself, you have the right to a copy of your file. Because these are professional records, they may be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them with me or have them forwarded to another mental health professional to discuss the contents.

If I refuse your request for access to your records, you have the right to have my decision reviewed by another mental health professional. We can discuss upon your request. You also have the right to request that a copy of your file be made available to other health care providers.

VI. CONFIDENTIALITY
My policies about confidentiality, as well as other information about your privacy rights, are fully described in a separate document entitled Notice of Privacy Practices provided to you. Please remember that you may reopen the conversation at any time during our work together.

VII. PARENTS & MINORS
While privacy in therapy is crucial to successful progress, parental involvement can also be essential. It is my policy not to provide treatment to a child under age 13 unless s/he agrees that I can share whatever information I consider necessary with a parent.

For children 14 and older, I request an agreement between the child and parents to share general information about treatment progress and attendance, as well as a treatment summary upon completion of therapy. All other communication requires the child's agreement, unless I feel there is a safety concern (see also above section on Confidentiality for exceptions). In this case, I will make every effort to notify the child of my intention to disclose information and handle any objections raised.

IX. OTHER RIGHTS
If you are unhappy with what is happening in therapy, I hope you will will talk with me so that I can respond to your concerns. Such comments will be taken seriously and handled with care and respect. You may also request that I refer you to another therapist and are free to end therapy at any time. You have the right to considerate, safe and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment. You have the right to ask questions about any aspects of therapy and about my specific training and experience. You have the right to expect that I will not have social or sexual relationships with clients or former clients.

X. CONSENT TO PSYCHOTHERAPY
Your signature below indicates that you have read this Agreement and the Notice of Privacy Practices and agree to their terms.

New Signature Field

Client Legal Name - First, Last

Date of Birth

Client Address