



CLIENT POLICY LETTER

CONFIDENTIALITY: All communication between therapist and client is strictly confidential unless: (1) The client signs a release of information form or otherwise authorizes the release in writing; (2) The therapist is ordered by a court to release or disclose information; (3) The client presents a physical danger to himself/herself or others; or (4) Child and/or elder abuse or neglect is suspected. In the latter two cases, the law mandates disclosure of information to potential victims and/or legal authorities so that protective measures may be taken.

FEES: Payment for services is an important part of any professional relationship. **Payment is expected at the time services are rendered.** Monthly statements will contain all pertinent data necessary for insurance purposes should the client choose to seek reimbursement. Any additional information required by an insurance company will be provided at no additional cost. Fees are reviewed and modified annually. Clients are notified of any change in fee 30 days prior to it taking effect. My fee schedule is:

<i>Individual Therapy:</i>	<i>1 hour (50 minutes)</i>	\$ _____
<i>Family/Couple Therapy:</i>	<i>1 hour (50 minutes)</i>	\$ _____
<i>Group Therapy:</i>	<i>1 hour (50 minutes)</i>	\$ _____
<i>Telephone Consultation:</i>	<i>½ hour (pro-rated for time needed)</i>	\$ _____
<i>Other Services:</i>		\$ _____

Telephone Consultation: Telephone consultation may be suitable or even necessary at times during the course of therapy. It involves professional services rendered with regard to your therapy, case planning, crisis management, and/or the imparting of information pertaining to your case. It includes conferences with other professionals or individuals such as physicians, lawyers, school counselors, and the like. Routine calls requiring 5 minutes or less will not be billed. There is no charge for calls regarding appointment scheduling or similar administrative business.

Reports and Correspondence: There is no charge for time spent writing simple reports to insurance companies. However, if a lengthy or complex report or correspondence becomes necessary, it will be billed at the regular therapy rate for time required. This is not an item covered by most insurance policies.

Supervision and Consultation: As a professional providing service, I will at times seek supervision, consultation and/or collaboration from appropriate professionals within this office to guarantee the best possible counseling services. It is understood that each professional consulted will maintain the confidentiality described above in paragraph one.

CANCELLATION: If you need to cancel an appointment, please do so at least **24 hours in advance**. Otherwise, you will be billed for the missed appointment at the regular rate.

DATE: _____ **PRINT NAME:** _____

CLIENT SIGNATURE: _____

THERAPIST SIGNATURE: _____