Record # __________

Professional Services Agreement

Receipt of Notice of Privacy Practices, Informed Consent, Release to Contact Payor(s), and Payment Agreement Form

Informed Consent: This agreement indicates my commitment to enter into treatment with the understanding of the basic ideas, goals, and methods of this therapy. I understand that periodic evaluation of these goals may change to best serve my long-term interest. At times, counseling may arouse unpleasant feelings and emotional experiences, particularly in the initial phase of treatment. The relationships with significant others may also undergo substantial change during the course of treatment. If treatment is terminated, I agree to schedule a closing session with the therapist to discuss progress, outcomes of treatment, and any further clinical recommendation. I acknowledge and give informed consent to treatment.

Counselor Limits of Confidentiality: Information discussed in the therapy setting is held confidential and will not be shared without written permission except under the following conditions:

1. The client threatens suicide or physical harm to another person(s), including murder or assault
2. The client reports suspected abuse of a minor child (under 18), a spouse, or the elderly including but not limited to physical beatings and sexual abuse.
3. The client reports sexual exploitation by a therapist.
4. The court orders the therapist to testify or release records to the court.
5. The client threatens or causes property damage to the counseling center or therapist's property.

State law mandates that mental health professionals may need to report these situations to the appropriate person and/or agencies. Further, as a registered resident/intern who is under the supervision of a licensed practitioner, therapy sessions will be discussed with a supervisor or professional colleague as deemed necessary. Communication between the counselor and client will otherwise be deemed confidential as stated under the laws of this state.

Payment Agreement: I understand that my payment is due at the time the services are rendered. Estimated payment information is listed at the bottom of this form. I understand that I will be billed a fee of **$40 for appointments not canceled 24 hours before the scheduled time.** (Appointment scheduled on Mondays must be cancelled by 3:00 pm on Friday before the appointment). If the office is closed or staff is unreachable, voicemail is available to give notice of cancellation. I am responsible for remembering my appointment. Returned checks are subject to a **$30.00** service charge and Footsteps will not accept any more personal checks for the duration of therapy. Unpaid balances that are more than 90 days past due are subject to a **1.5% per month service charge**. I understand that I am responsible for all charges incurred during the course of my treatment, including any portion of charges that insurance may not cover for any reason as well as any psychological testing. Written consultations and telephone consultations will be charged at the therapist's discretion and charges may apply. Requests for court services are **$150 per hour + travel expenses** (see legal expert witness form). Failure to make payment on an amount owed may necessitate at the discretion of Footsteps Counseling Center, the initiation of collections procedures, including possible legal action to recover the amount owed. The undersigned shall be responsible for any fees, including legal and collection agency fees, pursuant to this course of action. My signature below represents my understanding of this payment agreement. Footsteps Counseling Center is not responsible for co-pays and/or deductibles that may **differ from what is quoted by the insurance** when verifying benefits. The Client/Guarantor gives permission to Footsteps to contact any third party payor for payment.

X____ ________________________

Signature of Client or Guarantor Date

____ ________________________

Signature of staff witness Date

Permission to Communicate with YOUR PCP

In order to provide the best care possible, your counselor would like to communicate with your Primary Care Physician. This is often a mandate by certain manage care organizations.

Please check one: _______ I do ________I do not give Footsteps permission to exchange my protected health information with my PCP.

X____ ________________________

Signature of Client or Guarantor Date