Professional Services Agreement

I, _____, (Client OR parent/guardian of minor client, under 18)

PLEASE INITIAL:

_____**Have read and understand** the contents of the **Virginia Notice Form** which is posted in the waiting area regarding the Protected Health Information (PHI) held by Footsteps Counseling Center for requested services. I understand this information will be handled in accordance with the HIPAA Privacy Rule, which affords me specific rights and responsibilities regarding my PHI. This includes release of clinical information and reports to my insurance company in order to process my claims. *A copy of this notice will be provided upon request.*

_____**Give Informed Consent to Treatment** and this agreement indicate a commitment to enter into treatment with the understanding of the basic ideas, goals, and methods of this therapy. I consent to keep the therapist up to date about any changes in symptoms or situation that may impact the success of treatment. I understand that with periodic evaluation of these goals may change to best serve my long-term interest.

_____**Understand** that psychotherapy 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 recommendations.

_____ **Agree to pay** any monies and co-payments for which I am responsible in a timely manner. I will be responsible for all costs of collecting monies owed, including court costs, collections agency fees, and attorney fees if I fail to make any payments**. I also understand that there will be a missed appointment fee of $40.00 for appointments not cancelled at least 24 hours before the appointment.**

_____ **Understand the 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.

CONSENT TO CONTACT

In accordance with the HIPAA Privacy Rule, we cannot leave a message for a patient at their home or workplace either with someone or on an answering machine unless we have your consent.

Please initial one of the following statements to indicate your preference

_____**You MAY** make contact by phone to confirm appointments or notify me of cancellation by leaving a message at the following #'s:

_____ (home) _____ (work) _____ (cell)

_____ **You MAY NOT contact** me by phone to confirm appointments or notify me of cancellations by leaving a phone message. I will be responsible for keeping scheduled appointments and I **understand that a missed appointment fee will be charged for appointments cancelled less than 24 hours** in advance or for not showing up for an appointment.

_____ _____ _____

Signature of Client or Responsible Party Printed Name Relationship Date

_____ _____

Signature of Counselor Date

RELEASE OF INFORMATION FOR PCP

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

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

_____ Date _____

Signature of Patient or Guardian

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