**Transcend Counseling**

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Yorktown, VA 23692

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**COUNSELOR-CLIENT SERVICE AGREEMENT**

Welcome to Transcend Counseling. This document contains important information about the professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. Although these documents are long and sometimes complex, it is very important that you understand them. When you sign this document, it will represent an agreement between Transcend Counseling and yourself.

**PSYCHOLOGICAL SERVICES**

Therapy is a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. As a client in psychotherapy, you have certain rights and responsibilities that are important for you to understand. There are also legal limitations to those rights that you should be aware of. Your therapist has corresponding responsibilities to you. These rights and responsibilities are described in the following sections. Psychotherapy has both risks and benefits. Risks may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness, and helplessness, because the process of psychotherapy often requires discussing the 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 1-3 sessions will involve a comprehensive evaluation of your needs. By the end of the evaluation, your therapist will be able to offer you some initial impressions of what our work might include. At this point, we discuss your treatment goals and create an initial treatment plan together. You should evaluate this information and make your own assessment about whether you feel comfortable working with your therapist. If you have questions about the procedures, they should be discussed with your therapist whenever they arise. If your doubts persist, Transcend Counseling will be happy to help you set up a meeting with another mental health professional for a second opinion.

**APPOINTMENTS**

Appointments will be scheduled for a duration of 30, 45, or 60 minutes at a frequency agreed upon by both the therapist and the client. The need will be evaluated on an ongoing basis. The time scheduled for the appointment is assigned to you and you alone. Reminder messages are a courtesy of the office. It is the responsibility of the client and/or client’s guardian to remember the appointment, keep the appointment, or reschedule as required. It is your responsibility to arrive and be ready to begin your appointment at the scheduled time. If you are more than 15 minutes late it will be at the therapist’s discretion if a shorter time will be efficient time to follow through with the appointment, otherwise it will have to be rescheduled. If you need to reschedule or cancel an appointment a **minimum** of 24 hours’ notice is required. Any notice less than the required 24 hours will be considered a Late Notice Cancellation (LNC). It is the policy of the office to charge a fee of $50.00 if a Fail to Show (FTS) or a Late Notice Cancellation (LNC) occurs.

**Fail To Show/Late Notice Cancellation Policy for Repeated Occurrences**

***Please note from this point on the abbreviation for Fail to Show/Late Notice Cancellation will be FTS/LNC.***

This policy has been developed to specifically address the repeated occurrences of FTS/LNC and the impact this pattern has on the therapists and the need of other clients seeking therapeutic services.

In the case that two (2) consecutive FTS/LNC appointments happen, all future scheduled appointments will be cancelled. To reschedule an appointment All Outstanding Balances must be paid in full, along with a retainer fee of $50.00 to hold the future appointment. If this appointment is not kept, you will forfeit the $50.00. If the appointment **is** kept the $50.00 will be refunded back to you or it can remain as a credit for future expenses. **If within a 6-week period, a client has three (3) FTS/LNC occurrences, advanced appointments will no longer be available**. You may call to secure a same day appointment if the therapist has same day availability. A request to schedule advanced appointments may be made 60 days after the onset of same day scheduling has occurred. If a same day appointment is made and not kept, all services provided by Transcend Counseling will be terminated and recommendations for alternative agencies will be provided.

**PROFESSIONAL FEES**

Professional fees are as follows:

Licensed Professional Counselor

$125.00 - Initial Intake - 60 minutes

$105.00 - 60-minute individual/family/couples’ session

$90.00 - 45-minute individual session

$60.00 - 30-minute individual session

Resident in Counseling

$90.00 - Initial Intake- 60. Minutes

$85.00 - 60-minute individual/family/couples’ session

$75.00 - 45-minute individual session

$45.00 - 30-minute individual session

Report Writing: $25.00 for any psychological summary for insurance/disability/court

Court Fees: $150.00 per hour, with a minimum of 3 hours charged (1-hour for preparation, 1-hour for travel, 1-hour for court time). If time in court exceeds 1-hour additional time will be billed in increments of $75.00 per 30 minutes retained in court. If you anticipate becoming involved in a court dispute, it is recommended that this be discussed completely with your therapist before you waive your right to confidentiality. If another party issues a subpoena regarding your counseling services, it is expected that you will be responsible for all professional fees required from the subpoena.

Record Request: $15.00 handling fee plus an additional $0.30 per page. All requests must be made in writing and the fees paid before records will be released. The office has up to 15 days to comply with such a request.

**INSURANCE**

To set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it may provide some or all coverage for mental health treatment. With your permission, our billing service will assist you to the extent possible in filing claims and ascertaining information about your coverage. But you are responsible for knowing your coverage and for letting the office know if/when your coverage changes.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. Managed Health Care plans such as HMOs and PPOs often require advance authorization, without which they may refuse to provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person’s usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions.

You should also be aware that most insurance companies require you to authorize our practice to provide them with a clinical diagnosis. (Diagnoses are technical terms that describe the nature of your problems and whether they are short-term or long-term problems. All diagnoses come from a book entitled the DSM-5-TR. There is a copy in the office, and you are welcome to see it to learn more about your diagnosis, if applicable.) Sometimes insurance companies require additional clinical information such as treatment plans or summaries, or copies of entire records (in rare cases). This information will become part of the insurance company files and will probably be stored on a computer. Though all insurance companies claim to keep such information confidential, Transcend Counseling has no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. A copy of reports submitted are available to you upon request. By signing this Agreement, you agree that Transcend Counseling can provide requested information to your insurance carrier if you pay with insurance.

In addition, if you 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 payment of the appointment fee. Many policies leave a percentage of the fee (which is called co-insurance) or a flat dollar amount (referred to as a co-payment) to be covered by the patient. Either amount is to be paid at the time of the visit by cash/check or credit card. In addition, some insurance companies also have a deductible, which is an out-of-pocket amount, that must be paid by the patient before the insurance companies will begin paying any amount for services. This will typically mean that you will be responsible to pay for initial sessions until your deductible has been met; the deductible amount may also need to be met at the start of each calendar year. Once Transcend Counseling has all the information about your insurance coverage, we will discuss what we can reasonably expect to accomplish with the benefits that are 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 services yourself to avoid the problems described above, unless prohibited by the provider contract.

If your therapist is not a participating provider for your insurance plan, you will be supplied 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, your therapist can provide a recommendation.

**BILLING & PAYMENTS**

You will be expected to pay for each session at the time it is held, unless otherwise agreed upon or unless you have insurance coverage that requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested.

If your account has not been paid for more than **30 days** and arrangements for payment have not been agreed upon, Transcend Counseling has the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require disclosure of otherwise confidential information, such as, your name, the nature of services provided, and the amount due. If such legal actions become necessary, the legal costs will be included in the claim. In consideration of services rendered under this contract, the undersigned hereby agrees to pay 18% interest per annum on all balances, which are overdue, and agency or attorney fees, interest will continue to accrue, and you will be responsible for fees which are stipulated to be 35% of such outstanding balances, plus court costs and all other actual costs of collection, whether suit is filed or not.

**PROFESSIONAL RECORDS**

Your psychological services records are required to be kept and are maintained in a secure location in the office. These brief records note that you were here, your reasons for seeking therapy, the goals and progress set for treatment, your diagnosis, topics discussed, your medical, social, and treatment history, records received from other providers, copies of records sent 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, it is recommended that you initially review them with your therapist or have them forwarded to another mental health professional to discuss the contents. If your request for access to your records is refused, you have a right to have the decision reviewed by another mental health professional, which will be discuss with you upon your request. You also have the right to request that a copy of your file be made available to any other health care provider at your written request.

**CONFIDENTIALITY**

Policies about confidentiality as well as other information about your privacy rights, are fully described in a separate document entitled Notice of Privacy Practices. You have been provided with a copy of that document and will have discussed those issues. Please remember that you may reopen the conversation at any time during your work with your therapist.

**PARENTS & MINORS**

While privacy in therapy is crucial to successful progress, parental involvement can also be essential. It is our policy not to provide treatment to a child under age 13 unless she/he agrees that information can be shared, whatever considered necessary, with a parent. For children 14 and older, a request for an agreement between the client and the parents allowing general information to be shared about treatment progress and attendance, as well as a treatment summary upon completion of therapy. All other communication will require the child’s agreement, unless there is a safety concern (see also above section on Confidentiality for exceptions), in which case every effort to notify the child of the intention to disclose information ahead of time and make every effort to handle any objections that are raised.

**CONTACT/COMMUNICATION**

Please note that we are not readily available to speak with you outside of your scheduled appointment time as we are providing services to others. If a communication need arises outside of your scheduled appointment time you may contact the office via telephone or email. Please note that the telephone line is to the main office and not a direct line to your assigned therapist. The voicemail is reviewed by office staff and relayed to your therapist accordingly. If you choose to communicate via email, please note that your communication is not protected according to HIPAA guidelines. If the response contains any information that is defined as PHI (Protected Health Information) it will be encrypted to maintain confidentiality. If you do not see the response in your regular email review the junk or spam folder for a message from our secure messaging site.

We make every attempt to respond to your messages within 24-48 hours except for weekends/holidays/vacation time. Please note that the office is not open on Fridays.

This office does not offer On-Call Services for after hours. Therefore, in the case of an urgent need and/or if you feel that you are not safe, take action with one of the following options:

1) Contact “your” local Community Behavioral Health Services

2) Go to nearest Hospital Emergency Room

3) Call 911 and ask to speak to the crisis mental health worker on call.

**OTHER RIGHTS**

If you are unhappy with what is happening in therapy, we at Transcend Counseling, hope you will talk with your therapist so that she/he can respond to your concerns. Such comments will be taken seriously and handled with care and respect. You may also request that you be referred 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 specific training and experience. You have the right to expect no social or sexual relationships with clients or with former clients.

**CONSENT TO PSYCHOTHERAPY**

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

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Client/Parent/Guardian Signature Date

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Printed Name of Client/Parent/Guardian Representative

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Description of Personal Representative’s Authority (mother/father/guardian)

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Provider/ Witness Date