Providence Psychotherapy Marital/Couples Therapy Agreement

**Confidentiality**

All information between therapist and *client* is held strictly confidential unless:

1. The client authorizes the release of information with his or her signature.
2. The client presents as a physical danger to self or others
3. Child/elder abuse neglect suspected. \*Therapists are mandated reporters.

\*Your therapist ***does not assess*, make determinations or provide opinions of ability or disability to work, child custody, legal issues of divorce, mental competency, mental status, about any other legal issues, or** appear in court to provide testimony for any kind of court related case. You agree to this by signing this form

**Marital/ Couples Therapy Confidentiality Exceptions**

A ***no secrets*** policy applies in couples counseling. Secrets are counterproductive for creating healthy, connected relationships. If you have a secret, you find hard to share, either do not tell your therapist or let her know privately so she can help you process it and share it with your partner. It is understood that the couple *is the client* in couple’s therapy. If you participate in couples therapy, any individual sessions are considered under the marital/couples confidentiality agreement and are billed as such.

**Financial Agreement**

Fees for marital/couples therapy services are $150.00 for initial assessment session and $125.00 for (55 min) regular sessions. Sessions longer than 55 minutes are billed in increments per minute. Optional online Gottman Relationship Checkup Assessment available for $100. *By signing this form, you agree to pay all of your therapist’s expenses as well as time used in the process of recovering any outstanding balance for services.*

**Cancelled/ No Show Appointments**

If notice of cancellation is *not* given by text to 478-396-8388 more than 24 hours prior to the scheduled appointment time, you are responsible for paying a *no –show fee of $50.00*. There are no exceptions to this policy. \*You cannot cancel or reschedule an appointment by responding to an appointment reminder.

Your credit card on file will be charged in your absence. If your card is declined, you are responsible for paying the fee within 7 days of the missed appointment.

**Contact Information / Scheduling**

Text 478-396-8388. Your therapist will respond as soon as possible. Your therapist may be out of the office for trainings, illness or time off and cannot always guarantee weekly or biweekly appointments or specific regular appointment days or times. My therapist may contact me by phone, text, mail and email. Phone, text, mail and email are not HIPAA compliant means of communication. Download the pMD app for confidential texting.

**Emergency Procedures**

If you have an emergency, call 911. If you want a consultation outside of a session, text stating your need. Your therapist will respond at her soonest availability. Your credit card will be charged a fee for out of session consultations.

**Consent and Authorization for Therapy Services**

I authorize and request that my therapist carry out mental health assessments and treatments. I understand that although therapy is helpful, it can be uncomfortable at times. I enter into therapy services willing and so advised. No guarantees are made for results of therapy services. My therapist can discontinue services and refer elsewhere at any time she deems clinically appropriate.

By signing below, I attest that I have read, understood and agree to all of the above information.

Client’s Printed Names \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_\_\_

Client’s Signatures \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_