Providence Psychotherapy, LLC Patti McCurdy, LMFT

Marital/Couples Counseling 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 will not appear in court to provide testimony for any kind of court related case. You agree to this by signing this form. Your therapist will provide a brief letter verifying services for a fee of $50.00.

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 me or let me know privately. I can help you process it and share it with your partner. It is understood that the couple *is the client* in couple’s therapy.

**Financial Agreement**

Most insurance plans *do not* cover marital/couples therapy. If insurance is filed, the focus of the treatment is limited to treating the medical diagnosis of an individual member of the couple. Your insurance *may or may not* be filed as a service to you on a session-to-session basis. You are responsible for verifying insurance benefits *prior* to your appointment and for the ***full fee*** for therapy services each session. It is your responsibility to keep up with and advise your therapist of any changes in your insurance status, deductible, or co-pay amounts. Your therapist is not responsible for keeping up with your insurance benefits. Fees not covered by or insufficiently covered by your insurance are due at the time of service. Fees for marital/couples therapy services are $150.00 for an initial assessment and $100.00 for regular (50 min) sessions. Gottman Assessments are offered at a fee of $50.00 and are not covered by insurance*. \*A fee for filing insurance and using credit cards may apply each session. I agree to pay all of my therapist’s expenses and time used at the same rate for therapy services involved in recovering any outstanding balance for therapy 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*** . Appointment reminders are sent as a courtesy. Your credit card will be charged for said fee in your absence. If your card is declined, you are responsible for paying the fee within 7 days of the missed appointment. Insurance companies do not cover no-show fees. **\*You cannot cancel or reschedule an appointment by responding to an appointment reminder.**

**Contact Information**

Text 478-396-8388 or email pattiamelia@yahoo.com. I will respond as soon as possible.

**Emergency Procedures**

If you have a health related emergency of any kind, immediately call 911. If you need a consultation outside of a scheduled appointment time, text 478-396-8388 and state your need. I will respond by text at my soonest availability. There is a fee (*not covered by insurance*) for consultations outside of therapy sessions.

**Consent and Authorization for Therapy Services**

I authorize and request that my therapist carry out mental health assessments and treatments. My therapist may contact me by phone, text, mail and email. 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. Your therapist may discontinue services at anytime services are deemed therapeutically ineffective.

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

Client(s) Printed Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Client(s) Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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