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 $30.00.

**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**

Fees for marital/couples therapy services are $100.00 for (55 min) sessions. Sessions longer than 55 minutes are billed in increments per minute. Gottman Relationships Checkup Assessments are offered for a one time fee of $50.00. *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 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. **\*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. Insurance companies do not cover no-show fees.

**Contact Information**

Call or text me at 478-396-8388 or email me at pattiamelia@yahoo.com. If I do not answer, please leave a message. 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 phone consultation, text 478-396-8388 stating your need. Your therapist will call or text you back at her soonest availability. There is 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 authorize the release of my information as needed for healthcare management to my insurance provider. 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..

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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