Providence Psychotherapy, LLC Patti McCurdy, LMFT

Therapy Services Consent Agreement

**Confidentiality**

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

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

**\**To maintain confidentiality***, Your therapist will not speak to you outside of the therapy office ***unless*** you speak to her first. *It is not ethical for therapists to be personal or social media friends with clients or engage in social contact or social relationships with clients.* ***\*****Patti McCurdy* ***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.

**Financial Terms** Your therapist may or may not choose to file your insurance for you on a session-to-session basis. *You* are responsible for verifying insurance benefits *prior* to each appointment including confirming co-pay amount, co-insurance amount and eligibility and advising your therapist each session. You are responsible for maintaining your insurance records and for informing the therapist of changes in your deductible status, co-pay, or eligibility changes while receiving therapy services. If you make an error of underpayment, you are responsible for advising your therapist and paying the full amount due within 7 days of the discovered error. If you make an error of overpayment, you must request a refund within 7 days of the appointment of the overcharge to be refunded. The refund will be made for the overpayment amount *less t*he expenses the therapist has incurred collecting and/or refunding the overpayment including credit card processing charges. You are responsible for the full fee of therapy services. Fees are due at the time of service. Fees for therapy services are $150.00 for an initial assessment and $125.00 for regular (50-55 min) sessions. A discount *may or may not* be available each session for self-pay clients. *You agree to pay for your therapist’s time as well as all fees and expenses involved in collecting outstanding balances.* By entering into therapy and signing this form you agree to the financial terms outlined in this agreement and waive your ability to disagree in the future.

**Scheduling Policy:** Appointments are scheduled first come first serve based on the therapist’s current availability schedule. If an error in scheduling occurs your therapist will work in best effort to reschedule for you as soon as possible. Your therapist cannot guarantee availability of frequency, days or times for scheduling appointments.

**Cancelled Appointments** ***If notice of cancellation is not given by text to 478-396-8388 more than 24 hours in advance, you are responsible for paying a late cancellation fee of $50.00***. Insurance does not cover late cancellation fees. *You agree* for your credit card to be charged *in your absence for late cancellation fees*. If your credit card is declined you are responsible for making payment within 7 days of the missed appointment. Appointment reminders are sent only as a courtesy. **\*\*Appointments cannot be cancelled by responding to the appointment reminder system. There are no exceptions. Contact Information** Text **478-396-8388** or email **pattiamelia@yahoo.com**. *Text and email are not HIPAA compliant.* Do not use voicemail, text or email for information you want to remain confidential. **Emergency Procedures** If you have an emergency, immediately call 911 or go to the emergency room. You therapist does not provide emergency services or consultations outside of sessions.

**Client Consent and Authorization for Therapy Services** By signing this form, I authorize my therapist to carry out mental health assessments and treatments. My therapist may contact me by phone, text, mail and email and I understand the unsecure risk of such non-HIPAA compliant communication. 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, referring you to another therapist at any time at her discretion. By signing below, I attest that I understand, have fully read and agree to this therapy services agreement.

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

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

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**Cancellation Policy:**

*If notice of cancellation is not given by text to 478-396-8388 more than 24 hours prior to the appointment time, you are responsible for paying a late cancellation fee of $50.00.* Insurance companies do not cover late cancellation fees. Text is not HIPAA compliant. Do not text information you want to remain confidential.

*Your credit card will be charged in your absence for late cancellation fees. If your credit card is declined, you are responsible for making payment within 7 days of the missed appointment.*

Appointment reminders are sent as a courtesy via a one-way system. You cannot cancel an appointment or reach your therapist by responding to an appointment text or email.