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 Facebook or social media friends with clients or engage in social*

***\*Patti McCurdy does not appear in court*** *to provide testimony for any kind of court related case. You agree to this by signing this form. If you are seeking therapy for anything current or future court related, please ask for a referral to another therapist. A letter verifying therapy services or status of therapy can be provided for a fee of $50.00.*

**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 may request a refund within 7 days of the appointment. The refund will be made for the overpayment amount *less t*he expenses the therapist has incurred collecting or refunding the overpayment including a fee for the therapist’s time, credit card processing charges or taxes already paid. You are responsible for the full fee of therapy services. Your therapist is not responsible for keeping up with this for you. 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.

**Scheduled Appointments:** 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 as soon as possible. Your therapist cannot guarantee availability of days or times for future scheduling appointments.

**Cancelled Appointments** ***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 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 as a courtesy. **\*\*Appointments cannot be cancelled by responding to the appointment reminder system.**

**Contact Information** Text **478-396-8388** or email **pattiamelia@yahoo.com**. **Emergency Procedures** If you have a health-related emergency, immediately call 911. If you want an urgent therapy consultation, text 478-396-8388 stating your need. Your therapist will text you back at her soonest availability. There is a fee comparable to in session fees (not covered by insurance) for such consultations. You credit card will be charged accordingly.

**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) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Providence Psychotherapy, LLC**

**Cancellation Policy:**

**Cancelled Appointments** *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 no-show fees.

*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.*

\*\*To cancel/reschedule an appointment text 478-396-8388 with more than 24 hours notice. 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.

**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 may request a refund within 7 days of the appointment. The refund will be made for the overpayment amount *less t*he expenses the therapist has incurred collecting or refunding the overpayment including a fee for the therapist’s time, credit card processing charges or taxes already paid. You are responsible for the full fee of therapy services. Your therapist is not responsible for keeping up with this for you. 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.

I am aware of the cancellation policy and financial terms for therapy and agree to these policies fully by signing this form.

Printed Name(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_

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