

People United For a Common Cause, LLC

Service Contract

Individual Therapy

Please initial each paragraph and sign at the end

I am voluntarily entering outpatient treatment for problematic sexual behaviors, disruptive behaviors, boundary violations, substance use/misuse or mental health concerns.

I agree to take part in an initial clinical assessment billed at the below rate per hour. This assessment will determine my need for treatment, appropriateness for this office and level of care. If my therapist determines that I need a higher level of care, referral will be made for such.

I understand that each session is to be paid for at the time of billing. The rate for my outpatient session is _____. If I fail to cancel my session with 24 hours notice, I may be charged for that session. We will endeavor to utilize your insurance. However, you are responsible for the copay. Should your insurance not be applicable you will be billed the rate of \$150 (or your insurance's reimbursement rate). Insurance companies may not pay for various reasons, e.g. we are not in network, you don't have an applicable diagnosis to be billed, or you have not met your deductible.

I understand that my demographic information and other information necessary to bill my insurance will be shared with members of the group practice in order to effect billing.

I understand that therapy begins weekly or every other week, failure to regularly attend sessions can result in termination from therapy. After 3 no shows or cancellations, the termination process will begin.

My therapist and I will work together on treatment goals and regularly check the progress of those goals.

For sexual addiction clients or sexual offending clients, or substance abuse clients continued failure to maintain agreed upon behaviors may result in termination or recommendation to a higher level of care.

I will turn off (or silence) my cell phone during session.

I have the right to inspect my record with my therapist. While you may have a right to copies of your record, notes maybe redacted to protect you or others and are generally considered work product.

I have the right to informed consent about the treatment modalities being utilized.

I will not use alcohol or drugs on the premises and I will not attend sessions if under the influence of substances.

I will not have in my possession any weapons.

I will not make any threats of violence.

If I become a danger to myself, my therapist will take steps necessary to help me get to the appropriate level of care.

In the event of a medical emergency (e.g. heart attack, seizure) my therapist will take steps necessary to seek treatment for me.

If I am a minor (under the age of 18), I understand that my parents May have a right to my records and information about my treatment. Parents will be asked to sign below, asking them to respect the confidentiality of sessions, however, by law they may be entitled to information. **(Initial if a minor only)**

If my child is a minor, by law they may sign themselves into therapy. A child 14 or older may consent themselves to treatment and their parents may not object. A parent may also sign a 14 -17 year old in treatment without the minors consent. At this facility, we will not treat minors who do not consent to seeking treatment. Apprehension isn't lack of consent. Juveniles 14 and over generally control their own mental health records and release of this information is controlled by them, including to their parents. Minors 13 and under do not have control of their records or release.

However, we are asking that parents and guardians respect the therapeutic process and allow the children to control what information is given to their parents (excluding harm). By initialing this, parents are understanding and consenting to this. **(Initial only if a parent of a minor).**

___ Sessions are 45 to 60 minutes long, depending on therapist and insurance reimbursement and I am expected to be on time for the session and attend the entire session. If you are more than 15 minutes late for your session, your session is deemed cancelled.

___ My therapist's office number is not an emergency number. The phone will not be answered during session times. Messages will be returned within 24 hours M-F. If I have an emergency, I agree to seek care at my local hospital or call 911. **Your individual therapist will inform you if text is an acceptable form of communication.** Emails are also to be limited to general information (day and time of session e.g.) and not clinical issues or advice.

___ My therapist participates in group supervision with other members of the practice. Your information will be maintained with the utmost level of confidentiality while your therapist is seeking consultation and supervision.

Signature of Patient _____
Date _____

Witness _____
Date _____