**Professional Service Agreement**

Thank you for coming to Counseling Treatment Outreach for mental health therapy services. We look forward to working with you to improve your life and your relationships. This agreement is to clarify the business aspects of our relationship, and to help our therapeutic relationship go smoothly.

# Fees & Billing

* Payment is due in full at the beginning of each session by cash, check or credit card.

* Rates are subject to change at any time.

* There will be a $25 fee for any canceled check.

* If you are paying out of pocket for services (not billing insurance) you will receive a discount from the standard rates.

# Health Insurance Coverage

We will work with your insurance company to pay for your visit. However, all co-pays are due at the beginning of each session. If you insurance company does not pay for the visit, you will be responsible for the balance of all charges.

# Confidentiality

* The information you share will be kept confidential. I will ask you to sign a release-of-information form before discussing your treatment, or sending records about you to anyone else.
* Your confidentiality/privacy is protected by state law and by the rules of our profession, except in the following circumstances. The limits of confidentiality are:

1. **If you were sent to me by a court or an employer** for evaluation or treatment, the court or employer expects a report from me. You have a right to disclose only what you are comfortable with me telling.
2. If you are **involved in a lawsuit**, and you tell the court that you are in therapy, I may then be ordered to show the court my records. Please consult your attorney about these issues.
3. If you **threaten to harm** yourself or another person, the law requires me to try to protect you and/or that other individual.
4. If I believe a **child, an elderly individual, or a vulnerable adult has been or will be abused or neglected**, I am legally required to report this to the authorities.
5. If I **bill your insurance** it will have a mental health diagnosis listed and it will become part of your permanent medical record.
6. In order to provide you with the best treatment I may **consult with other mental health professionals** about your case.

# Late Cancellation/No Show Policy

If you are unable to make your scheduled appointment, please cancel at least 24 hours in advance so another client can be scheduled during that time. If 24 hours notice is not given, you will be charged the full session amount.

# In Case of Emergency

If you are experiencing an emotional, behavioral, or medical crisis, call 911 or go to the nearest emergency room. We do not provide 24-hour crisis services.

**I understand, and agree to, the policies as stated above, and I give consent for treatment by Counseling Treatment Outreach.**

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Client’s Name Date

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Client’s (or Responsible Party’s) Signature Relationship to Client Date