Clinician-Client Agreement and Financial Responsibility

Thrive Counseling Services is a business facility with Licensed Professional Clinical Counselors and Licensed Professional Counselor. **Your contract for services is with your therapist only.**

Informed Consent:

- You may ask questions about any aspect of the counseling process, and have the right to make informed decisions about you or your child's care and will be provided information about the services you receive, as well as those services that may be recommended
- You have the right to refuse and recommend service and discontinue service at any time.
- If you have been referred by a court or state agency, you have the right to divulge only what you want to be included in a report.
- Therapy is most effective when you are open and can speak honestly about your emotions and experiences.
- Therapy may include talking about emotionally provoking subjects and scenarios.

Confidentiality:

- Information shared by you in session will be kept confidential.
- Information will not be released without your written consent, except for professional consultation if needed and unless required by law.
- We are required by law to disclose information pertaining to suspected child abuse, the inability to care for one's basic needs for food, clothing or shelter, and threatened harm to oneself or others.
- The court may subpoena counseling records.
- It is understood that information regarding treatment and diagnosis may be provided to an insurance company.
- State law mandates that mental health professionals may need to report these situations to the appropriate professionals and/or agencies.
- Communication between the clinician and the client will otherwise be deemed confidential as stated under laws of the state.

Discontinuation of Services:

- Treatment goals have been met to your satisfaction
- Cancelling or failing to show for 2 appointments without a valid reason
- Refusing to be an active participant in the treatment process

Appointments:

- All office visits are by appointment.
- Please arrive on time, as you use up your own time when you arrive late for an appointment. The usual length of an appointment is 60 minutes.

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- Late cancellation (less than 24 hours before) appointments are billed to the client in the amount of $50.00. No Show are billed to the client in the amount of $100.00. In the case of illness, please notify us no later than 9:00 a.m. the day of the appointment. Please leave a message if you get voice mail. If your appointment is cancelled or missed, contact the office for a new appointment time. Insurance companies will not pay for no-show charges or late cancellation charges or for telephone consultations.

Fees:

- The client portion (co-pay) of fees is expected at the time of service.
- Insured clients are expected to take care of their fees as services are rendered. My office will bill your insurance company for services provided. You will receive a statement each month reflecting any balance due on your account. This office cannot accept responsibility for collecting your insurance claims or for negotiating a settlement on a disputed claim. You are responsible for payment (and insurance claims) on your account. ***Failure to pay your part may jeopardize your benefits. Copays are not negotiable***.
- Clients paying on a cash basis, and not billing any insurance company are expected to pay in full at time of service unless a payment plan has been previously arranged.
- Except in the case of minors or when other arrangements are made, the person receiving the counseling service is financially liable.
- Accounts become delinquent after thirty (30) days. ***Accounts 90 days in arrears will be terminated***.
- Any change in my financial situation I will discuss with my therapist. In the event you find it necessary to change mental health providers and require records to be sent from **(Elyse Etapa, LLC)** your account will need to be paid in full.

I have read, understand and agree to the above policies. I have been offered a copy of these policies to take with me if desired. I hereby authorize **(Elyse Etapa, LLC)** and my therapist to release any information acquired in the course of my therapy to my insurance company (if client is a minor, parent or guardian sign). I understand my insurance coverage is a relationship between me and my insurance company, and I agree to accept financial responsibility for payment of charges incurred. I understand that a re-billing fee/financial charge complying with (Ohio) State Law will be applied to any overdue balance, and in the event of non-payment, I will bear the cost of collection and/or court costs and reasonable legal fees should this be required. I have read and/or received a copy of **(Thrive Counseling Services)**'s Privacy Policy

Initial Visit/Assessment:	**$110.00**
Session Fee (60 min):	**$100.00**
Late Cancellation:	**$50.00**
No Show:	**$100.00**
Bounced Check Fee:	**$25.00**

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Emergencies:

The **best phone number** for the office is **(330-703-6578)**. If you receive the voice mail, please leave a message. Your counselor may be on the phone, in therapy with someone else, or out of the office. In a crisis situation, and your therapist cannot be reached you may **call the 24-hour Mental Health Crisis Line: (330-452-9812), *or* go immediately to your local hospital emergency room.**

Client(s) Signature(s): _____

Date:_____

Therapist Signature: _____

Date:_____