Journeys Counseling
1052 University Ave. Dubuque, IA 52001
(563)213-5050

Counseling Agreement for Ashlee Weber, LMHC

I am pleased that you have chosen me as your counselor. The following information is designed to inform you of my qualifications and of the terms for working together in a professional relationship.

Qualifications: I am a Licensed Mental Health Counselor (LMHC) by the State of Iowa. I have been a professional counselor since 2011. I continue to do my own personal growth and health work, as well as ongoing professional trainings.

Standard Fee: $190/hour. Fees are based on the time I spend with you and includes time spent writing and processing your records. The first appointment typically lasts an hour and is normally bill for $200 due to the additional time involved in setting up your chart. A normal counseling session last 50-60 minutes.

Fee Payment Schedule: Full payment is required at the beginning of each session. I am willing to arrange a payment schedule if needed. Future appointments may be delayed if your account has an outstanding balance. If, after 2 notices, arrangements have not been made to insure payment, your account may be turned over to an outside agency for collection.

Insurance: If you wish to seek reimbursement for counseling services, please contact your insurance provider for an explanation of benefits, also known as an EOB. This will clarify whether or not your plan covers counseling services with this therapist, what your deductible is, how many sessions are covered, your co-payment amount, etc. If you know that your insurance will cover counseling expenses, you may wish to send in a claim on your own behalf. After you've paid for your counseling session, I will give you a claim form containing all of the information your insurance needs so that they can reimburse you for counseling payments.

Failure to Keep Your Appointment: Your appointment time is reserved for you in advance and cannot be assigned to anyone else on short notice. Therefore, it is necessary that you cancel your appointment at least 24 hours in advance to avoid a late cancellation charge. No show appointments are considered any appointments that are scheduled that you do not present for. The fees for late cancellations/no shows are as follows:

- The first failure to provide 24 hours notice will result in a **$25** fee being assessed (unless there is a legitimate emergency).
- A second occurrence will result in a **$50** fee.
- Any additional occurrences after that will result in your full appointment fee being assessed.

** Any costs accrued for late cancels/no shows are the responsibility of the client to pay**

Client Name:_____ DOB:_____/_____/_____

Mental Health Emergencies/After Hour Crisis: My counseling services are limited to the scheduled sessions we have together. In the event you feel your mental health requires emergency attention or if you have an emotional crisis, you should report to the emergency room of the local hospital and request mental health services. If needed, you may call during office hours to see about making arrangements to be seen sooner than your next scheduled appointment.

Confidentiality: Communications between counselor and client are private and confidential. This confidentiality is protected by law, and is extremely important to the maintenance of a productive therapeutic relationship; as a result, I will take any and all action necessary to protect the disclosure of such information for use in legal proceedings without the consent of the client. If the client is a minor child, you, as parent or guardian, by signing this agreement agree and acknowledge that you will not seek to obtain the mental health records of the minor child, or compel testimony relating to counseling with the minor child, in any legal proceedings. If you do seek such records for use in legal proceedings, you agree to pay any and all costs and reasonable attorney fees I incur in defending the confidentiality of such records.

Court Involvement: Time spent preparing for court, traveling to and from court, and participating in court proceedings will be billed the full standard rate of $300/hour. The adjusted fee is not applicable in these circumstances. It is this clinician's decision to not participate in legal and adversarial situations such as custody disputes and litigation between parties. The focus of counseling services is to provide symptom relief and growth.

Your Rights: As a recipient of the counseling services, you have the right to refuse and /or terminate counseling at any time, the right to a description and explanation of your treatment, and the right to confidentiality. Be apprised that in order to provide the most effective services possible, I routinely participate in confidential case consultation with other members of the counseling staff, disclosing information only to the extent necessary to achieve the purpose of the consultation. Information revealed during your session will be kept strictly confidential and will not be revealed to anyone without written authorization. The law provides for the following exemptions to your right of confidentiality: I determine that you may be a danger to yourself or to others or someone is causing harm to you (this includes child or elder abuse and/or neglect), or I am being ordered by a court to discuss information about your treatment. If you have questions or concerns, please ask.

PLEASE COMPLETE AND SIGN: I hereby certify that I have read and understand the preceding information and I willingly enter into this counseling relationship with Ashlee Weber, LMHC. I understand that I am personally financially responsible for all charges not covered by insurance or that it is my obligation to pay for counseling services provided at the rate of $_____ per hour, and that full payment is due at the beginning of each session.

If filing with my insurance company, I authorize payment of benefits, directly to Ashlee Weber, LMHC. I also authorize Ashlee Weber, LMHC to contact my insurance company if any additional information about my coverage is needed and to release all diagnostic and treatment information essential to

Client Name:_____ DOB:_____/_____/_____

complete my claim. My signature below acts as signature on file, authorizing the release of insurance payments.

_____ ____/____/____

Signature of client (First name, initial, last name) Date

_____ ____/____/____

(If applicable) Signature of Parent/Guardian Date

Address:_____ City:_____ State:_____ Zip:_____

Client's Date of Birth: ____/____/____

Home Phone:_____ Work:_____Cell:_____

In case it is necessary to be contacted about your appointment time, can you be contact at home?

Yes___ No___

Can you be contacted at work? Yes____ No____

Can message be left with others or on your voicemail/answering machine? Yes____ No____

Would you prefer an automated 24-hour reminder of your appointment? Yes____ No____

If so, how would you prefer your reminder to be sent? Email_____ Text Message____ Both____

Where did you hear about Journeys Counseling?_____

Thank You!