Journeys Counseling

Counseling Agreement ~Doris A. Schmitt, LMHC

It is a privilege that you have selected me to provide you with professional counseling services. The following information is designed to inform you of my qualifications and the terms of our working together within our professional counseling relationship.

Qualification: I am a Licensed Mental Health Counselor by the State of Iowa. I have over 20 years experience.

Standard Fee: $150/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 billed for 1.25 hours due to the extra time involved in setting up your chart. A normal counseling session lasts 50 - 60 minutes.

Fee Payment Schedule: Full payment is required at the conclusion 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 (E.O.B.). 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-pay 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 appointments: 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. The first failure to provide 24 hour advance notice will result in a **$25** fee being assessed (unless there is a legitimate emergency). A second occurrence will result in a **$50** fee, and any additional occurrences after that will result in your **full appointment fee** being assessed.

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 a 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 proceeding. 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 and traveling to and from court will be billed double the full standard rate of $150/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.

NAME: _____ DOB:_____

Your rights: As a recipient of 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 exceptions 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 and/or neglect), or I am 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 Doris A. Schmitt, LMHC. I understand that I am personally financially responsible for all charges not covered by insurance and 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 conclusion of each session.

If filing with my insurance company, I authorize payment of benefits, directly to Doris A. Schmitt, LMHC. I also authorize Doris A. Schmitt, 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 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_____

Date of Birth___/___/___Home Phone:_____Work_____Cell _____

In case it is necessary to be contacted about your appointment time, can you be contacted at home?
YES____NO_____. Can you be contacted at work? YES____NO_____.
Can messages be left with others or on your answering machine? YES____NO_____.
Where did you hear about Journeys Counseling?_____E:
Thank you –

NAME:_____ DOB:_____