

**CLIENT COUNSELING AGREEMENT, OFFICE POLICIES
and GENERAL INFORMATION**

1. Fees	
Initial Assessment (60 minutes)	\$155
Couples (50 minutes)	\$125
Individual Integrative (60 minutes)	\$110
Late Cancellation/Missed Appointment Fee	\$70*

All payments are due at the time of session.

*Your consistent attendance greatly contributes to the success of your therapy. In addition, the scheduling of an appointment involves **the reservation of time set aside specifically for you**. Accordingly, a \$70 fee will be charged for sessions missed or cancelled **with less than 48 hours notice**. **Two NO SHOWS or late cancellations may result in termination of treatment**. In case of illness, please contact Breathtaking Holistic Counseling Services (leave a message if necessary) by 8:00 A.M. the day of your appointment.

Please note that due to scheduling, your late arrival to an appointment cannot be made up at the end of your session.

2. Insurance

Breathtaking Holistic Counseling Services is a fee for service provider and does not participate in insurance. At the time of service, you will receive a receipt which you can submit to your insurance company for any reimbursement to which you may be entitled under your insurance plan.

3. Marriage/Relationship Therapy

If you participate in marital, couple, or relationship therapy, I will not disclose confidential information about your treatment to anyone unless all adult person(s) who participated in the treatment with you provide their written authorization to release such information, or if required by law.

4. Confidentiality

All information disclosed in therapy sessions is confidential and may not be revealed without the client's written permission except under the following circumstances: **Under federal and state laws, confidentiality can be breached to ensure safety when:**

- The therapist considers the client a risk to self or others.
- Abuse of a child is reported.
- A court ordered subpoena is received.
- Authorized federal officials are conducting an investigation related to national security and intelligence activities in regard to the Patriot Act. By law, therapists cannot reveal when such a disclosure has been made.

5. Emergencies

If there is an emergency during our work together, where I become concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychiatric care, I may take reasonable steps, within the limits of the law, to prevent you from injuring yourself or others and to ensure that you receive the proper medical care. For this purpose, I may also contact the person whose name you have provided on biographical sheet.

In the event of a medical emergency or an emergency involving a threat to your safety or the safety of others, please call 911 to request emergency assistance.

6. Legal Matters

Due to the nature of the therapeutic process, it is my decided preference not to be involved in legal proceedings which would necessitate my disclosure of information regarding your therapy with me. Accordingly, I ask that I not be called to testify by you, your attorney or anyone else acting on your behalf in any legal proceedings (such as, but not limited to divorce and custody disputes, workers compensation or other lawsuits for personal injuries, unless I am a Defendant in the suit).

7. In My Absence

At times, I may need to reveal your name and phone number to particular therapists covering my practice in my absence.

8. E-Mails, Cell Phones, Computers and Faxes

Please be aware that information shared via e-mails, cell phones, computers and facsimiles are subject to hackers and other mechanisms of possible compromise. Please proceed accordingly and limit the information you share with me through these mediums.

9. Therapist Availability & Emergency Procedures

If you have an urgent need to speak with me between office visits, please leave a message for me on my confidential voice mail, briefly describing the reason for your call; I will typically return your call within 48 hours. I take vacations and will do my best to provide reasonable advance notice when I do.

10. Discussion of Treatment Plan

Within a reasonable period of time after the initiation of treatment, I will discuss with you (client) my working understanding of the problem, treatment plan, therapeutic objectives and my view of the possible outcomes of treatment. If you have any unanswered questions about any of the procedures used in the course of your therapy, their possible risk, my expertise in employing them or about the treatment plan, please ask, and I will do my best to answer your questions.

11. Termination:

I do not accept clients who, in my opinion, I cannot help. If initially or at any point during psychotherapy, I conclude that I cannot help you, I will discuss it with you and, if appropriate, terminate treatment. In such a case, I would provide you with contact information for alternate providers as appropriate. If authorized in writing, I will talk to the psychotherapist of your choice in order to help with the transition. You have the right to terminate therapy at any time. Often the desire to leave therapy can arise from feelings of discomfort or fear, or the feeling that nothing is happening, when in fact these feelings often precede an important breakthrough. I ask therefore that you participate in a final session prior to termination.

REQUEST FOR TREATMENT

I have read the foregoing carefully and I understand its contents. All my questions have been answered. I am requesting treatment for myself and/or _____ from Cheryl Rowland at Brehtaking Holistic Counseling Services.

I CONTRACT AND AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SESSIONS INCLUDING ANY SCHEDULED APPOINTMENT MISSED OR CANCELED WITHOUT **48 HOUR NOTICE**, WHICH WILL RESULT IN A \$70 FEE as further described herein.

Signature of Client: _____ Date: _____

Relationship to Client (if signed by Personal Representative) _____

CLIENT'S ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES AND OTHER DOCUMENTS

I acknowledge that I have read and received the following:

- Notice of Privacy Practices Statement**
- The Therapy Process - What to Expect & Consent Form**
- Client Rights and Responsibilities Statement**
- Release and Waiver of Liability**

Signature of Client: _____ Date: _____

Relationship to Client (if signed by Personal Representative) _____