Services

Appointment Cancellation/ Rescheduling

_____ Regular attendance to your scheduled appointments is very important to a successful outcome in therapy. I have reserved an hour or more for your appointment. Appointments cancelled at the last minute are detrimental to my practice and to your treatment. A minimum notification of one full business day prior to your appointment (24 hours in advance Monday through Friday) is required for cancellations or you will be charged a cancellation fee of $75.00. Repeated late cancellations or missed appointments (more than 2) will be billed at the full fee and may result in termination of therapy. In addition, if you arrive more than 15 minutes late to an appointment, you will be billed for a full session. The session will only be for the scheduled time and will not run over. If you are billing an insurance company, you will be responsible for payment for the session due to the change in time.

Appointment availability varies with the client load and time. High demand appointments (off hours, late afternoons, evenings, and weekends) are likely to be sporadic in their availability and will not be available to those who late cancel or no show. I reserve the right to limit my commitments of high demand appointment times to any particular client in order to meet the needs of all of my clients and balance my workload.

If you no show for an appointment, all future appointments will be cancelled. Clients cases will be closed unless contact is made with the clinican. Two late cancellations will cause cases to be closed unless clinician is made aware of the issue and is willing to keep the case open.

Documentation

_____ I will not testify in court for the purposes of custody. Guardians can request documentation to take to court. Requests can take up to twenty-one days but no sooner than fourteen days to be in receipt of the information.

Financial Obligations

_____ Payment is expected at the time the service is rendered. Co-pays must be paid at the beginning of each session. By the signing this document you are agreeing to pay for services rendered and any additional expenses that may be accrued in collecting said fees. If you are not paying by insurance my discounted rates are as follows:

Initial Intake: $275.00

Individual 45 minute therapy session: $200.00

Individual 50-55 minute therapy session $250.00

Couples/Family Session: $250.00

Late Cancellation Fee: $85.00

No Show: Full payment is expected for scheduled session.

***Other professional services: Will be billed in 15 minute increments at the rate of $250.00**

Telephone consults, telephone or text sessions, coaching sessions, report writing, coordination with other professionals, preparation of records, or treatment summaries beyond session will be billed at the reate of $125.00.

____Legal services (court appearances) and associated travel time will be billed at $400.00 per hour.

____I reserve the right to change my fees or stop taking an insurance due to non-payment with 30 days' notice and to use services of a third party collection service, when necessary. Refunds are not made after the services have been rendered. You have the right to be informed of all fees that you are required to pay and my policies.

Litigation Considerations

_____ If you become involved in the legal system (divorce, custody, civil litigation, criminal activity, etc) you can expect that I will not make recommendations, testify, or get otherwise involved in your legal activities. It is inherent conflict of interest for a treating professional to offer evaluations or opinions in legal matters. If a client has these expectations, it can affect their willingness to disclose personal information vital to treatment. If you need an evaluation for he legal reason, I will make a referral to an outside, unbiased professional who can perform this service. In signing this agreement, you agree that you will not call me as a witness to testify or to expect recommendations or other involvement in your legal activities.

Social Media/Voice Mail/Texting/Email

_____ Due to HIPAA privacy laws a provider cannot text or leave a message without a consent from you stating that a voicemail, email, or text can be left or sent. Please initial and writer the number below and the email that Apple Blossom Counselling can contact you at with your permission.

Phone Number: _____

Email: _____

_____Due to my professional ethical practices, I will only respond to texts to schedule, confirm, or cancel appointments. Likewise, emails are strictly for scheduling, confirmation, and or cancellation of an appointment. Please note that I cannot guarantee an immediate response to your text and or emails and will respond within a 24 hour period. In addition, I will not "like" you or accept a

Friend request on Facebook or any other social media including Linked in. The adherence to these codes maintains ethical practice.

Dual Relationships

_____ Our relationship is very unique and it is exclusively a therapeutic, professional relationship. Thus, it is inappropriate for a client and therapist to have a social relationship. Consequently, you may bump into me out in the community. I will never acknowledge working therapeutically with you without your written permission. In addition, bestowing gifts and attending family or religious functions would be a violation of the boundaries or our therapeutic relationship that serves to protect your confidentiality.

Fees and Payments

____ Due to co-pay payments and fees for a no show appointment, a credit card will need to be put on file for the account. You credit card will never be billed without your knowledge. This will be collected with your insurance card at the very first visit.

By signing below. I am stating that I am aware and agree to the policies of Apple Blossom Counseling, LLC.

_____ _____

Client/Guardian **Date**

_____ _____

Clinician **Date**