Reflections Psychotherapy, P.C.
Therapist-Client Service Agreement

This document contains important information about our professional services and business policies. You will also have an opportunity to review information about the Health Insurance Portability and Accountability Act (HIPPA), a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment and health care options. The law requires that we obtain your signature acknowledging that I have provided you with this information at the first session. When you sign this document, it will represent an agreement between you and Reflections Psychotherapy, P.C. Please carefully review the following information and feel free to ask any questions you may have.

Psychotherapeutic Services

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the mental health professional and the client, as well as the particular problems you are experiencing. There are many different methods we may used to deal with the problems you hope to address. Psychotherapy is a collaborative effort between therapist and client. In order for therapy to be successful, it will call for a very active effort on your part.

The first few sessions will involve an evaluation of your needs. By the end of the evaluation, your therapist will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue therapy. You should evaluate this information, along with your own opinions of whether you feel comfortable engaging in this process. Therapy often involves a large commitment of time, money and energy, so you should be careful about choosing a therapist. If you have any questions about our procedures, they can be discussed whenever they arise. If, for whatever reason, we do not feel like a good "fit" for you, your therapist will be happy to provide you with referrals to another mental health professional.

Sessions

Therapy sessions are generally between 45-55 minutes in length. Sessions may take place in our clinical offices or by Telehealth.

Cancellations

We would greatly appreciate notification of the need to cancel a scheduled session as early as possible. **Once an appointment is scheduled, you will be expected to pay for it unless you provide a minimum of 24 hours advance notice of cancellation. It is important to note that insurance companies do not provide reimbursement for cancelled sessions; therefore, you will be charged for the full session fee, not just the amount of your co-payments.** Please be aware that frequent cancellations may result in your therapists' inability to hold a set appointment time slot for you, especially for appointments after 3pm.

Professional Fees

Initial Diagnostic Interview appointment fees are **$175**. Once treatment has begun, the standard fee for a 45 minute Individual Session is **$150** and **$160** for a 55 minute Individual session. Family Therapy sessions are **$150**. In addition to scheduled appointments, your therapist may charge this amount on a prorated basis for other professional services you may need, including report writing, preparation of records, or telephone conversations lasting longer than 5-10 minutes.

Payments for services are required at the time they are provided. All clients are required to have an active credit card on file, which will be set up during the first appointment. At that time it will be discussed if this card will be used for ongoing session fees, or if an alternate method of payment is preferred. All balances not paid within 30 days will automatically be charged to the card on file. If checks are used, you will be responsible for all bank fees, if returned from the bank. Each month you will receive a statement showing sessions, charges and payments. These statements will contain all the information necessary for you to file for any benefits you may be eligible.

Insurance

As Licensed Clinical Social Workers, a portion of our services are typically eligible for reimbursement from health insurance companies. Currently, this practice is a preferred provider for BCBS PPO, and will submit claims on the behalf of clients with this carrier. As there are many different BCBS policies, you are responsible for knowing your individual benefits/ coverage. It is crucial that you find out if pre-certification is required for services and any exclusions of services. For clients wishing to file claims with other insurance carriers, monthly statements containing all required information will be provided to the client or responsible party.

Contact Procedures

Our clinicians are not immediately available by phone, but a message can be left on our therapists' confidential voicemail at any time of the day. Every effort will be made to return your call within 24 hours, with the exceptions of weekends and holidays. If your therapist will be unavailable for any extended time (e.g., vacation), coverage will be provided. Please let your therapist know if there are any special instructions regarding leaving messages with family members or co-workers. ****Please note that our office does not communicate any clinical issues through text messaging.**

This office does not provide emergency services. In the event of an emergency, please contact the appropriate service (i.e., police, fire, hospital). Your therapist will assist in the development of a detailed crisis plan.

Confidentiality

Your therapist is ethically bound to keep all shared information confidential. In order to ensure your protection and the welfare of others, there are occasions when the law requires exceptions from this policy. For example, all therapists are mandated reporters and must report all suspected abuse and neglect. Children between the ages of 12 and 18 may limit access to their parents and others to their records. It is our belief that the best interest of children and their families are served by a reasonable expectation of confidentiality. Please feel free to express specific concerns you have with this position.

Professional Services and Policies
Agreement Summary & Consent

I, _____, understand and agree to the following:

Review of HIPPA Privacy Notice Initials_____

Review of No Surprises Act Initials_____

Receipt of Psychotherapy-Client Service Agreement Initials_____

Fee Policies Initials_____

Unless otherwise arranged, I will provide payment in full at the time of service. I agree to keep a current credit card on file and understand that it will be charged for any unpaid balances extending beyond 30 days. In the event of a returned check, I understand that I will be responsible for reimbursement of the check amount plus payments of any applicable service charges. Standard sessions are **$150** for 45 minute Individual Sessions and **$160** for 55 minute Individual Sessions. Family Therapy sessions are **$150,** and are generally 50 minutes in length. Limited or extended sessions are pro-rated. Extended phone calls will be charged at the same rate as office visits. Should my account be referred to an attorney or agency for collection, I will be responsible for applicable attorney/collection fees.

Insurance (BCBS Clients only) Initials_____

I authorize payment of medical benefits from my insurance company to Reflections Psychotherapy, P.C., for all services rendered. I authorize this therapist to file insurance claims for the cost of services rendered. I authorize this therapist to submit to my insurance company or their representative any clinical information about my diagnosis and treatment that is necessary to authorize services and/or to process these insurance claims. I understand that I am responsible for knowing my own insurance coverage and limitations, and when pre-certification is required. I understand that said benefits are not a guarantee of payment and that I am responsible for the entire bill including any deductibles or expanses insurance does not cover.

Missed Sessions Initials_____

I am responsible for the full cost of any scheduled appointment that I cancel or miss **without a minimum of 24 hours** advance notice. These charges are not covered by insurance plans.

Emergencies Initials_____

I understand that this office does not provide emergency services. In the event of an emergency, I know to contact the appropriate emergency service (i.e., police, fire, hospital). This office can assist in the development of a detailed crisis plan as needed. My emergency contact will be contacted as necessary.

_____ _____

Client Signature Date

_____ _____

Parent and/or Guardian Signature Date