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TREATMENT AGREEMENT

Patient's NAME:_____

Please initial in each box on the left after reading the text to the right:

	FEES: The fee for a 45-minute session is $ 195.00, and $260.00 for a 60-minute session. Payments are due at the time of our session in cash, check, or credit card. Fees are the same for video, phone, or in-person sessions.
	CANCELLATION: Sessions are by appointment only. While I hate charging for missed sessions, I do reserve that time for you. Therefore, you will be charged the full amount of the session if you cancel without a 24-hour notice. Since your time is also valuable, if I forget a session, you get one session free.
	INSURANCE: I do not bill any Insurance, including Medicare. I provide you with an invoice if you wish to seek reimbursement from your medical Insurance plan or if you need it for tax purposes.
	COUPLE WORK: If you come to see me to address problems you experience in a relationship, the relationship is my patient. I will address relational problems in joint sessions and individual sessions, as needed.
	LENGTH OF TREATMENT: The length of treatment will depend on our Treatment Plan, as prepared with your approval and discussed with you. The treatment may require regular appointments or appointments on an as-needed basis.
	TREATMENT PLAN UPDATES: Treatment will be reviewed once a year and updated according to need and goals. The treatment Plan reflects our work together. It is thus a collaborative endeavor as long as the treatment is beneficial to you.
	CONFIDENTIALITY: What you say in therapy, your records, and your attendance are all confidential. Exceptions to confidentiality include when your records are subpoenaed for legal reasons, and when reporting is required or allowed by law. The law requires reporting of suspicion of child abuse or neglect, bullying, danger to self, suspected elder abuse, and suspected danger to others. Other exceptions to confidentiality are when you give written permission to release information.
	IN AN EMERGENCY: Contact me via e-mail, text, or voicemail. You may also go to the emergency room or dial 911. You may also be aware of 988, which is the suicide hotline.
	E-MAIL/SOCIAL MEDIA: In general, e-mail is the quickest way to reach me. I use email to arrange/change appointments. When cancelling, please leave BOTH a voicemail and an email. Please do not e-mail me information related to your therapy, as e-mail is not completely confidential, and important issues should be reserved for sessions. Be aware that e-mails between us become part of your legal record.

INITIAL BELOW	*Treatment Agreement (continued from Page 1)*
	CLINICAL RECORDS are kept in writing and are always locked up in my filing cabinet to protect your privacy and confidentiality.
	REFERRALS: In my opinion, a referral to another provider may become necessary because your issues would be better treated by a professional with different expertise. It is unethical for me to practice beyond the level of my competence, education, training, or experience. I am not responsible for the care received from professionals to whom I refer you.
	ENDINGS: If you are unhappy with any aspect of therapy, please don't just leave – I ask that you talk to me to see if we can work it out. Even if we can't, endings usually feel better this way. Of course, you may end therapy at any time, and I am happy to assist with referrals. It is my ethical duty to provide therapy only when I feel you are actively participating and benefiting from the sessions.
	PATIENT RIGHTS: You have the right to ask any questions about your treatment or refuse to participate in treatment at any time. This office does not discriminate in the delivery of healthcare services based on race, ethnicity, national origin, citizenship or immigration status, religion, gender/gender identity, age, mental or physical disability, medical condition, sexual orientation, medical history, evidence of insurability, or source of payment.
	COMPLAINTS: The Arizona Board of Behavioral Health receives and responds to complaints regarding services provided within the scope of practice of Counseling/psychotherapy.
	PRIVACY PRACTICES: By initialing here and signing below, you are acknowledging receipt of my *Notices of Privacy Practices*. My *Notice of Privacy Practices* provides information about how I may use and disclose your private health information. I encourage you to read it in full. My *Notice of Privacy* Practices is subject to change. If I change my Notice, I will give you a revised Notice. If you have left treatment, you may obtain the revised notice from me at the above address and phone number

By signing below, I acknowledge that I have read and understood the above rights and policies.

Signature	Printed Name	Date
Signature, second patient	Printed Name, second patient(if applicable)	Date