Eden Counseling Center

Professional Services Agreement

I, _____, (Patient OR parent/guardian of minor client, under 18)

_____ *initial* **Have read and understand** the contents of the **Virginia Notice Form** (*A copy of this notice will be provided upon request.)* regarding the Protected Health Information (PHI) held by ECC for requested services. I understand this information will be handled in accordance with the HIPAA Privacy Rule, which affords me specific rights and responsibilities regarding my PHI.

_____ *initial* **Give Informed Consent to Treatment-** My consent indicates a commitment to enter into treatment with the understanding of the basic ideas, goals, and methods of this therapy. I consent to keep the therapist up to date about any changes in symptoms or situation that may impact the success of treatment. I understand that with periodic evaluation of these goals may change to best serve my long-term interest.

_____ *initial* **Understand** that psychotherapy may arouse unpleasant feelings and emotional experiences, particularly in the initial phase of treatment. The relationships with significant others may also undergo substantial change during the course of treatment. If treatment is terminated, I agree to schedule a closing session with the therapist to discuss progress, outcomes of treatment, and any further clinical recommendations.

_____ *initial* **Understand the Counselor Limits of Confidentiality** Information discussed in the therapy setting is held confidential and will not be shared without written permission except under the following conditions:

1. The patient threatens suicide or physical harm to another person(s), including murder or assault
2. The patient reports suspected abuse of a minor child (under 18), a spouse, or the elderly including but not limited to physical beatings and sexual abuse.
3. The patient reports sexual exploitation by a therapist.
4. The court orders the therapist to testify or release records to the court.
5. The patient threatens or causes property damage to the counseling center or therapist's property.

State law mandates that mental health professionals may need to report any of the above situations to the appropriate person and/or agencies. A registered resident/intern who is under the supervision of a licensed practitioner will discuss therapy sessions with a supervisor or professional colleague as deemed necessary. Communication between the counselor and patient will be confidential as stated under the laws of this state.

CONSENT TO CONTACT

In accordance with the HIPAA Privacy Rule, we cannot leave a message for a patient unless we have your consent. Patients must text 622622 to EdenCC to authorize text message reminders.

Please initial <u>one</u> of the following statements to indicate your preference for contact.

_____ **<u>You MAY contact</u>** me by phone for appointment reminders or to notify me of a cancellation by leaving a phone message or text at the following #.

_____ (home) _____ (work) _____ (cell)

_____ **<u>You MAY NOT contact</u>** me by phone for appointment reminders or notify me of cancellations by leaving a phone message**.** I will be responsible for keeping scheduled appointments and I understand that a missed appointment fee may be charged for appointments cancelled less than 24 hours in advance or for not showing up for an appointment.

_____ Signature of Patient or Responsible Party _____ Printed Name _____ Relationship to patient _____ Date

_____ Signature of Counselor _____ Date

Patient Name_____ Patient ID_____ Entered in pt Acct: Initial_____Date____

PSA10-2013

Eden Counseling Center

Payment Agreement

We believe that a clear understanding of our financial policies is important for both client and therapist. We are fully committed to helping you accomplish the goals you establish when you enter counseling and to help you maximize your investment of time and finances. We will deal with you fairly, equitably and with sensitivity in financial matters. The following information clearly describes our financial policies. ***A copy for your records will be provided upon request.***

PATIENT NAME _____ **PATIENT** Date of birth ___ ___/___ ___/___ ___ ___ ___
LAST, FIRST, MI

INSURANCE INFORMATION

- **I agree to pay my co-payment, coinsurance, and/or deductible *at the time of service.***
- **As a courtesy we will verify insurance benefits. *Any co-payment, coinsurance, or deductible we charge are based on the benefits provided by the insurance company(s)*** Patients are responsible for any outstanding balance *in the event that the insurance carrier denies benefits, changes co-payment, alters your deductible, retracts a payment, or does not provide benefits as estimated. Patient or Responsible Party is responsible for the balance regardless of the reason the insurance denies coverage.*
- **Patients must notify our office of any changes to their insurance *no later than 48 hours prior to an appointment*** or patient may be responsible for the full standard fee for that appointment.

SELF PAY INFORMATION *(The Self Pay Rate is discounted from the Standard Fee.)*

- **I agree to pay the Self Pay rate of $ _____ per session *at the time of service*.**
- **If payment is NOT made *at the time of service* the patient will forfeit the discounted rate and will be charged the full Standard Fee for that service date** *(Standard Fees are based on service type and provider.)*

PAYMENT INFORMATION

- **Full payment is due at the time service.** *Credit cards, cash and checks are accepted.*
- **Patients will incur a monthly interest rate of 1.67% (APR of 20%) if their account balance is not paid in full within 30 days of the billing date.** *Patient will be responsible for payment of these charges, as well as any collection costs including, but not limited to, attorney fees should collection become necessary.*
- **Patients will be charged $35 for a return check or returned credit card payment.**

MISSED APPOINTMENT FEE

- **Patients will be charged $80.00 for a missed appointment fee *for appointments that are cancelled less than 24-hours in advance*. Patients may phone the office anytime to cancel an appointment.** *If the office is closed, you may call the office at 757-466-3336, press option 5and follow the prompts to leave voicemail. Messages are date/time stamped.*
- **Missed Appointment fees are not covered by insurance and are the responsibility of the patient.**

ADDITIONAL CHARGES

- **Patients are responsible for additional charges for services agreed upon by the patient and therapist** that are incurred during the course of treatment, including psychological testing, reports, and letters.
- **After hour's calls, written consultations and telephone consultations of ten minutes or more will be charged at the therapist's discretion and disclosed to the patient.**

I accept financial responsibility for the patient account and the terms of the payment agreement.

_____ ___ ___ ___-___ ___-___ ___ ___ ___ ___ ___/___ ___/___ ___ ___

Name of **Patient/Responsible Party***(if minor)* **Responsible Party** Social Security # **Responsible Party** Date of birth

_____ _____ _____

Signature of **Patient/Responsible Party***(if mino* Date Relationship to patient

Witnessed by: ECC staff_____ Date_____

Payment Agreement 10-2013 Patient Id_____ Resp. party entered pt acct: Initial _____ Date_____