Claremont Counseling and Support Center, A Psychological Corporation
Therapy Agreement

It is important that you understand your rights and obligations relating to your counseling experience. Carefully reading the information below will help you avoid any subsequent surprises. Please feel free to discuss any questions you have concerning this information with your therapist.

About your therapist…

1. Your counselor is:
   A) a licensed ____Marriage & Family Therapist ____Psychologist ____MD
   B) registered ____MFT Intern ____Psychological Assistant
2. If your counselor is not presently licensed, he/she is under weekly supervision with a licensed supervisor(s).

About your therapy sessions…

3. Your counseling sessions will be **45-50 minutes**/full session, 25 minutes/half session: [ind/couple/family/group]
4. Estimated term of therapy is _____ sessions.
5. **The fee** for therapy is _____ (full) _____ (half) per session. MEANS OF PAYMENT:
   $_____CASH/Check/Credit Card – to be made prior to the start of each session.
   _____I understand that I will be responsible for billing my own insurance company. I also understand that my provider at Claremont Counseling and Support Center will provide me with a Superbill at my request but that they cannot guarantee payment by my insurance company.
   _____Therapist is a provider for my insurance and will bill accordingly.
   _____Other payment arrangement.
6. On occasion your counselor may deem it necessary to utilize particular testing instruments to expedite and enhance the quality of treatment. An additional fee will be charged for each test administered.
7. Appointments must be cancelled *24 hours in advance excluding holidays and weekends*. For instance; if calling to cancel for a Monday appointment, the cancellation must be made by Friday. If cancelling over a holiday the holiday itself does not count as normal business hours. In the case of a late cancellation, *a full session charge* will be made directly to the office by the client.
8. A TELEPHONE ANSWERING SERVICE IS AVAILABLE FOR AFTER-HOURS MESSAGES. Telephone conversations with your counselor exceeding 5 minutes will be billed in 15 minute increments. All calls are time and date stamped.
9. Audio or video taping of your sessions may be conducted, on occasion, if you are seeing a pre-licensed counselor. Tapes will be used for supervision purposes only and then erased. This is to ensure the quality of service you deserve.
10. As a training clinic, a co-counselor may work with your therapist on occasion.
11. According to California laws any kind of sexual contact, or asking for sexual contact, or sexual misconduct by a psychotherapist with a client is illegal, as well as unethical (Business & Professional Code Section 726, 728, and 498 (k)).
12. Professional consultation: Therapist participates in clinical, legal and ethical consultation with appropriate professionals. During consultations, therapist will not reveal any personally identifying information regarding client.
13. Email is not a confidential form of communication and should not be used to discuss any kind of confidential information.
14. Therapists can sometimes provide letters for clients for certain needs, and the fee per letter written to the client is $75.

About your financial responsibilities…

15. I, the undersigned, hereby understand that payment of each session is due prior to each session unless other arrangements are agreed upon in writing. In the event that credit arrangements have not been agreed upon in writing and the charges have not been paid within 30 days of the due date, I agree that the charges will be subjected to a **late charge of 1.5% per month** on the unpaid balance. **The charge for a returned check is $30.**
16. I, the undersigned, hereby agree that in the event of default in the payment of any amount due, my name and other relevant information may be released by this therapist in order to recover such overdue balances.
17. I, the undersigned, have read and fully understand the responsibility of this agreement. I have received a copy of this agreement and herein agree to abide by all the conditions set forth above.

_____
Please Print Client Name

_____ _____
Client Signature Date

_____ _____
Therapist Signature Date