Eden Counseling Center

Professional Services Agreement

I, _____ (Patient or Responsible Party if Patient is a Minor, under age 18)

_____ **I have been informed of the Virginia Notice Form** *(*A copy of the notice is posted and will be printed upon request.)
Initial in regards to my Protected Health Information (PHI) held by ECC for requested services. I understand PHI will be handled in accordance with the HIPAA Privacy Rule, which affords me specific rights and responsibilities.

_____ **Give Informed Consent to Treatment-** My consent indicates a commitment to enter into treatment with the
Initial 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.

_____ **Understand** that psychotherapy may arouse unpleasant feelings and emotional experiences, particularly in the
Initial 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.

_____ **Understand the Counselor Limits of Confidentiality.** Information discussed in the therapy setting is held
Initial 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.
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 contact the patient or leave a message without the patients consent. No clinical, diagnostic or insurance information will be left on a voicemail or email unless prior authorization is given to the practice.

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

_____ **You <u>MAY NOT</u> contact me** by Phone and/or Email to speak with or leave a message. I understand that I am responsible for keeping my appointments and that a missed appointment fee of $60 will be charged for appointments canceled less than 24 hours in advance.

_____ **You <u>MAY</u> contact me** by Phone and/or Email to leave a message for appointment reminders or to notify me of a therapist cancellation at the following phone number(s)

Preferred Contact: _____ cell _____ home _____

Alternate Contact: _____ cell _____ home _____

Email Address: _____

_____ _____ _____

Signature of Responsible party Date Relationship to Patient

_____

Printed Name of Responsible party

Payment Agreement

Eden Counseling Center

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. The following information clearly describes our financial policies.

PATIENT NAME _____ **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, or does not provide benefits as estimated. This includes but is not limited to retraction of a payment, deductibles, cost share and errors by the insurance carrier. Patient or Responsible Party is liable for the balance regardless of the reason the insurance denies coverage.
- I understand that services can be suspended if I am not willing to make a payment arrangement, or pay any outstanding balance, including missed appointment fees and copayments

SELF PAY INFORMATION

- I agree to pay the Self Pay rate of $ _____ per session **at the time of service.**
- Doctors $180 Initial appointment/ $120 each subsequent visit
- LPC/LCSW $120 Initial appointment/ $80 each subsequent visit

PAYMENT INFORMATION

- Patients will incur a **33 1/3 %** collection fee on their account if the balance is not paid in full within 60 days of the billing date. Patients will be responsible for payment of these charges, as well as any collection costs including, but not limited to, attorney fees/collection agency fees should collection become necessary.
- A $35 returned check fee will be added to any balance when an item is returned

MISSED APPOINTMENT FEE

- Patients will be charged $60.00 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 3 and leave voicemail. Messages are date/time stamped. You may also contact your provider of the designated voicemail line they have given out.
- 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 account and the terms of the payment agreement.

_____ ___-___-____ __/__/____

Name of Responsible Party | Responsible Party Social Security # | Responsible Party Date of birth

_____ _____ _____

Signature of Patient/Responsible Party | Date | Relationship to Patient

Witnessed by: _____ Date _____ Chart # _____