COUNSELING CONTRACT

Lynda Green-Alter, MFT

PATIENT AGREEMENT: I agree to attend the scheduled appointments with all designated family members. Regular sessions are 45 minutes in length. I myself or as the undersigned parent(s) or legal guardian(s) of ____, a minor, do hereby consent to counseling services by the above-named counselor. This authorization shall remain in effect until revoked in writing by the undersigned.

APPOINTMENTS: Time is specifically reserved for your therapy session by agreement with you. If you need to cancel or change an appointment time, please give 24 hours advance notice. **Cancellation without 24 hours advance notice will result in you being charged for the session.** Three (3) or more late cancellations or "no shows" may result in termination of treatment. Please help us to serve you better by keeping scheduled appointments. This fee is NOT covered by insurance, so it will be your personal responsibility.

Cancellation without 24 hours advance notice during regular business hours will result in you being charged for the session at the rate of: $ 175.00 ______________ (patient's initials)

Please note your appointment time and date. The placement of confirmation calls or reminder calls is not standard policy. A major credit card will be required to be kept on file for processing payment based on my cancellation policy.

PAYMENT: Payment is due at the time of service. We accept cash, credit cards, debit cards and personal checks. No third party checks are accepted. Returned checks are subject to a $35.00 service fee and may result in loss of check payment option. Overdue accounts will be referred to a collection agency. Legal fees that we pay to secure past due balances will be added to your account.

CONFIDENTIALITY: My legal and ethical responsibilities require that our sessions remain confidential. As a result, I will only release clinical information to another professional or agency with your written consent. Only necessary or pertinent information will be shared with written authorization. There are some exceptions under which I am required by law to share information with specific outside parties. These situations would include actual or potentially dangerous behavior towards yourself, towards others or in the case of child abuse.

PATIENT AUTHORIZATION: It is with my full understanding and consent that information about my case may be exchanged with Lynda Green-Alter, MFT and her staff in the capacity of providing assessment and referral, billing and collecting fees and offering ancillary recovery services.

STATEMENT OF FINANCIAL ARRANGEMENTS FOR PROFESSIONAL SERVICES RENDERED: Please read this document carefully, for it describes the financial policy of this office. Any exceptions to this policy must be in writing and signed by all parties involved. It is expected that full payment will be made at the time services are rendered, in the form of cash, check, money order or credit card. If special arrangements are necessary, these need to be discussed with Lynda Green-Alter, MFT in advance.

It is understood that you are responsible for any charges made. Payment for all co-payments, co-insurance or deductible is expected at time of service. It is also understood that, if for any reason, the insurance company does not pay the full amount verified, denies any charges for services that are rendered or if the yearly or lifetime maximum amount is exceeded, that any remaining balance will be the full responsibility of the patient. Any services not covered by insurance or done outside of session time, such as, but not limited to, reviews with managed care, consultations, phone consults, report writing, etc., will be at my regular fee rate. My regular fees are $165 per therapy session (regular sessions are 45 minutes in length).

FINANCE CHARGES: If patient balances are not paid on date of service, finance charges will be applied. Finance charges are not covered by insurance, so it will be your personal responsibility.

I am generally available via telephone in case of an urgent or emergency situation which cannot wait until our regular scheduled session. Please remember, I may not be able to return your call immediately. When I am out of town, I will generally have another therapist answering calls for me.

My signature below indicates I agree to the terms and conditions outlined in this document. I have completely read, fully understand and agree to the above terms and information. I understand and agree to the Financial Policy.

Dated: ____________________ ____
Signature of Patient

Dated: ____________________ ____
Signature of Parent / Legal Guardian