

Jillian Foster LCSW, LCAS 30 Hendersonville RD Suite 1

Asheville, NC 28803

# THERAPIST-CLIENT SERVICE AGREEMENT

Welcome to the first step of this new journey! I am deeply honored and privileged you are choosing to begin this process with me. I have the utmost respect for your courageous choice to walk this path. My hope is that you will feel safe and unconditionally accepted here, and that you will find whatever you are seeking on all levels.

This document contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations.

PSYCHOLOGICAL SERVICES

Therapy is a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. As a client in psychotherapy, you have certain rights and responsibilities that are important for you to understand. There are also legal limitations to those rights that you should be aware of. I, as your therapist, have corresponding responsibilities to you. These rights and responsibilities are described in the following sections.

Psychotherapy has both benefits and risks. Risks may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness, because the process of psychotherapy often requires discussing the unpleasant aspects of your life. However, psychotherapy has been shown to have benefits for individuals who undertake it. Therapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems. But, there are no guarantees about what will happen. Psychotherapy requires a very active effort on your part. In order to be most successful, you will have to work on things we discuss outside of sessions.\_\_\_\_\_\_(client’s/guardians initial) APPOINTMENTS

Appointments will ordinarily be 45-55 minutes in duration, once per week at a time we agree on, although some sessions may be more or less frequent as needed. The time scheduled for your appointment is assigned to you and you alone.

Cancellation Policy for Existing Client Office Visits:

*All appointments cancelled less than 48 hours from the scheduled appointment time will be billed at the full office visit fee. Monday appointments must be cancelled on the Friday before 12 noon prior to your appointment.*

It is important to note that insurance companies do not provide reimbursement for cancelled sessions; thus, you will be responsible for the full rate. In addition, you are responsible for coming to your session on time; if you are late, your appointment will still need to end on time. This an important part of the accountability and boundaries process that takes place in a healthy therapeutic relationship. \_\_\_\_\_\_ (client’s/guardians initial)

Snow/Inclement weather policy:

In the event of inclement weather, alternatively we will meet remotely via zoom/skype or phone. If you decline alternative session format or miss your scheduled session due to weather you will be charged for the full rate of the session.\_\_\_\_\_\_\_\_\_

**PROFESSIONAL FEES**

**Individual:**

**30 minutes $100.00 50-minutes: $175.00 75-minutes: $190.00 90-minutes: $250.00**

**Couple or Family:**

# 60-minutes: $250.00

These rates are subject to change. You are responsible for paying at the time of your session unless prior arrangements have been made, including paying all fees at end of month as discussed with clinician. Outstanding balances exceeding 30 days past due will be charged a 10% service charge. Any checks returned to my office are subject to an additional fee of up to $25.00 to cover the bank fee that I incur. If you refuse to pay your debt, I reserve the right to use an attorney or collection agency to secure payment. (Payment can be made in cash, check or card. Payment is due on date service is rendered. “I grant permission for my credit card on file to be charged for balance due not resolved in with other form of payment or in the event of any missed session without 48 advance hours notice per the cancellation policy.” If I am needed to testify in court, or attend other meetings, I can do so for an additional charge that we will discuss prior to my attendance in these situations.

Legal Fee schedule:

Court appearance as expert witness- $250/hr including travel to and from location

Assessment Letter- $150-$250 per official professional letter

Telephone remote legal testimony/ cross examination - $250 per hour

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (client’s signature and date )

INSURANCE

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. With your permission, I will assist you to the extent possible in filing claims and ascertaining information about your coverage, but you are responsible for knowing your coverage and for letting me know if/when your coverage changes. Please note that I will assess the full difference of session rate from the amount your insurance reimburses, regardless of the “contracted” rate. \_\_\_\_\_\_ (client’s/guardians initial)

You should also be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. Sometimes I have to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit, if you request it. By signing this Agreement, you agree that I can provide requested information to your carrier if you plan to pay with insurance.

In addition, if you plan to use your insurance, authorization from the insurance company may be required before they will cover therapy fees. If you did not obtain authorization and it is required, you may be responsible for full payment of the fee. Many policies leave a percentage of the fee (which is called co-insurance ) or a flat dollar amount ( referred to as a co-payment ) to be covered by the patient. Either amount is to be paid at the time of the visit by check or cash. In addition, some insurance companies also have a deductible, which is an out-of-pocket amount,

that must be paid by the patient before the insurance companies are willing to begin paying any amount for services. This will typically mean that you will be responsible to pay for initial sessions with me until your deductible has been met; the deductible amount may also need to be met at the start of each calendar year. \_\_\_\_\_ (client’s/guardians initial)

If I am not a participating provider for your insurance plan, I will supply you with a receipt of payment for services, which you can submit to your insurance company for reimbursement. Please note that not all insurance companies reimburse for out-of-network providers. If you prefer to use a participating provider, I will refer you to a colleague. \_\_\_\_\_ (client’s/guardians initial)

PROFESSIONAL RECORDS

I am required to keep appropriate records of the psychological services that I provide. Your records are maintained in a secure location in the office. I keep brief records noting that you were here, your reasons for seeking therapy, the goals and progress we set for treatment, your diagnosis, topics we discussed, your medical, social, and treatment history, records I receive from other providers, copies of records I send to others, and your billing records. You also have the right to request that a copy of your file be made available to any other health care provider at your written request.

\_\_\_\_\_\_ (client’s/guardians initial)

CONFIDENTIALITY

I am required by my licensing board and HIPPA policies to ensure to my utmost ability that your privacy is protected. Therefore I will not share any information you share with me, or other identifying information with anyone for any reason other than a life-threatening emergency. \_\_\_\_\_\_\_ (client’s/guardians initial)

CONTACTING ME

I am often not immediately available by cell phone 828-367-7715 or email openheartasheville@gmail.com. I do not answer my phone when I am with clients or otherwise unavailable. At these times, you may leave a message on my confidential voice mail and your call will be returned as soon as possible, but it may take a day or two for non-urgent matters. You can text me for scheduling purposes only please !!!! If, for any number of unseen reasons, you do not hear from me or I am unable to reach you, and you feel you cannot wait for a return call or if you feel unable to keep yourself safe, 1) contact Mobile Crisis Management **1-800-849-6127** 2) go to your Local Hospital Emergency Room, or 3) call 911 and ask to speak to the mental health worker on call. I will make every attempt to inform you in advance of planned absences, and provide you with the name and phone number of the mental health professional covering my practice. \_\_\_\_\_(client’s/guardians initial)

OTHER RIGHTS

If you are unhappy with what is happening in therapy, I hope you will talk with me so that I can respond to your concerns. Such comments will be taken seriously and handled with care and respect. You may also request that I refer you to another therapist and are free to end therapy at any time. You have the right to considerate, safe and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment. You have the right to ask questions about any aspects of therapy and about my specific training and experience.

CONSENT TO PSYCHOTHERAPY

Your signature below indicates that you have read this Agreement and the Notice of Privacy Practices and agree to their terms.

I agree to all of the above criteria of this Informed Consent document.

Signature of Patient/or legal guardian (if under 18)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_date\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name of Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_