Family Options Counseling, LLC
Client Service Agreement and Financial Responsibility

Clients Name: _____

Informed Consent:

- Voluntary:
    - I am voluntarily consenting to treatment or assessment for the named client and have the option to withdraw from services at any time.
    - I understand that this consent to treatment / assessment will be in effect for the duration of one year, unless I withdraw my informed consent in writing.
- Risks and Benefits:
    - I understand that no guarantees are made to me about the results of treatment or assessments.
    - I understand the plan for treatment / assessment and understand the potential risk and benefits of the treatment / assessments.
    - I understand the alternative treatment options.
    - I understand that I have the option to withdraw from services at any time.
- My Responsibility:
    - I understand that it is my responsibility to inform the assigned clinician if there are any changes in my condition (or the minor receiving services).
    - I acknowledge that I have received a copy of the Privacy Practices and Grievance Procedure for Family Options Counseling.
    - I understand that if the client is a minor, I will participate in treatment / assessment services as agreed upon with the assigned clinician.
    - I understand that it is my responsibility to attend scheduled therapy appointments. It is also my responsibility to cancel any appointments 48 hours prior to the session so that time can be used by someone else in need. I understand that I may lose my therapy time if I do not show up for my appointments.

Confidentiality and Its Limits:

- Our Responsibility Regarding Your Information:
    - I understand the Privacy Practices that was provided to me to begin services at Family Options Counseling. I am comfortable asking my clinician further questions about my confidential information.
- Mandated Reporting:
    - I understand that the clinician's at Family Options Counseling are mandated reporters for suspected abuse of children or vulnerable adults. I understand that if I report abuse to a child or a vulnerable adult, that the clinician(s) will have to report it to the appropriate social service agency and / or legal authorities.

- Duty to Warn / Protect:
    - I understand that if I disclose intentions or a plan to harm another person and have the ability to carry out that plan, my clinician(s) are required to warn the intended victim and inform the legal authorities. I also understand that if I disclose intentions to harm myself (or minor child discloses intentions), my clinician(s) are required to report this to the appropriate authorities or family members.

Phone Sessions / Electronic Communication:

- I understand that I can not participate in phone sessions at Family Options Counseling. Phone communication is appropriate for scheduling purposes and providing brief updates typically when the client is a minor.
- I understand that I will contact my clinician directly if I need to cancel / reschedule an appointment and I will not rely on third parties.
- I understand that text messaging and emailing is not an appropriate mode of therapeutic communication and that my therapist will be unable to respond through text messages. Text messaging and email communication may be an appropriate mode to schedule appointments if agreed upon by myself and my clinician.

Insurance Companies or Contracted Third Party Payors:

- I understand that I am providing permission for Family Options Counseling, for the purpose of payment for services, to disclose information to insurance companies or contract agencies that may be responsible for the payment of my services.
- I understand that it is my responsibility to inform Family Options Counseling of any changes to my insurance or enrollment in third party contracts. It is ultimately my responsibility to pay for any services that are not paid for by my insurance company or contracts.
- I understand that I have the right to review my history of services and payments by requesting this information from my clinician.
- I understand that if I do not provide payments or agree to a payment plan in a timely manner, my outstanding invoice may be turned over to a collections agency.

Financial Agreement:

- I agree to the following financial agreement between myself and Family Options Counseling.

- My insurance information:
    - Primary Insurance:_____
    - Secondary Insurance:_____
    - Tertiary Insurance:_____

- My preference is to utilize the sliding fee scale that Family Options Counseling offers. In order to utilize this scale, I understand that Family Options Counseling will not process any claims through insurance.
    - Based on my annual income of _____, and the number of people supported by this income, I agree to pay _____ per session. I have provided a copy of my most recent pay stub.

Following is a list of the fees for services at Family Options Counseling. If a contract exists with a third party payor, those agreed upon fees will be billed. If a third party payor authorizes the services through a contract agreement, Family Options Counseling will not send an invoice to the client.

Type of Service	**Masters Licensed Training Level**	**Therapist / Master's Level**	**Psychologist / Doctoral Level**
Intake Evaluation	$150.00	$200.00	$300.00
Individual / Family Therapy	$100.00 per hour	$150.00 per hour	$200.00 per hour
Group Therapy	$60.00 per hour $90.00 per 1.5 hour	$60.00 per hour $90.00 per 1.5 hour	$60.00 per hour $90.00 per 1.5 hour
Testimony	$100.00 per hour	$100 per hour	$200.00 per hour

By signing this agreement, I agree to the terms of this contract and agree to the financial responsibility outlined in this contract.

_____ _____
Guardian/Client Printed Name Date

_____ _____
Guardian/Client Signature Date

_____ _____
Client Signature (14 years and older) Date

_____ _____
Therapist Date