ReEvolve, LLC
Solutions for Optimum Living
Licensed Clinical Social Worker-Life Coach

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Client Consent and Payment Agreement

INFORMATION ABOUT YOUR CONSENT FOR THERAPY

Congratulations for taking this important and courageous first step, and welcome to my professional services. For best results and your own welfare, it is important that you understand what it means to be in therapy. Please read the following information ***carefully***. If you have any questions or concerns, please feel free to discuss them with me at any time.

WILL THERAPY HELP?

The most common benefits of therapy include improvements in self-awareness, self-esteem, and self-confidence, as well as in hope, feeling understood, relationships with other people, emotional expressiveness, and taking an active and responsible role in one's life. There can also be risks associated with being in psychotherapy. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. You may already be in the midst of stressful changes or challenges in your life. My role is to help you to cope with these challenges in ways that serve your well-being and that of the people in your life. Periods of change are often stressful, and they are sometimes stormy. You may experience a range of emotions and changes in your relationship with yourself and others (including me). It is extremely rare for people to be harmed by their experience in therapy.

WHAT WILL PSYCHOTHERAPY COST?

*****PAYMENT IS REQUIRED AT THE TIME SERVICES IS RENDERED *****

ReEvolve accepts payments in cash, credit, check, and, when applicable, via claims through certain insurance plans.

Professional Fees: Standard therapy sessions are 45-50 minutes in duration. The initial session fee is $160.00; subsequent sessions are $130.00 for individual therapy, $150.00 for couples' or family therapy, and $165 for 75-minute sessions. Group therapy sessions are $60.00. In addition to weekly appointments, I charge $65.00 per hour for other professional services you may need, though I will

pro-rate the hourly fee for periods of less than one hour. Such other services include, but are not limited to, report writing, telephone conversations lasting 15 minutes or longer, consulting with other professionals where you have authorized contact, preparation of records or treatment summaries. If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time including preparation and transportation costs, even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge $250.00 per hour (with a minimum engagement of three (3) hours) for preparation for and attendance at any legal proceeding. Client/Guardian Initials: _____

Cancelled/Missed Appointments Fees: Once an appointment is scheduled, you will be expected to pay for it unless you provide 48 hours advance notice of the cancellation [unless we both agree that you were unable to attend due to extraordinary circumstances]. All appointments that are cancelled less than 48 hours prior to the scheduled appointment time will be billed at $50 fee. All missed appointments which were not cancelled at all will be billed at the cost of $60. It is important to note that insurance companies do not reimburse for cancelled or missed sessions. You understand that you will be fully responsible for these fees. Please feel free to discuss any questions and concerns regarding this policy. Client/Guardian Initials: _____

Transfer of Records: You understand that you will be charged a fee to transfer your records to another physician: $15.00 for records thirty (30) pages or less in length, and $30.00 for records exceeding thirty (30) pages in length. This payment is due in full prior to the copying and forwarding of records. Client/Guardian Initials: _____

Assignment of Benefits: By initialing below, you hereby authorize payment of all medical insurance benefits which are payable under the terms of your insurance policy to be paid directly to ReEvolve, LLC. for services rendered. You further authorize the release of any information needed for the purposes of treatment, payment and health care operations, including, but not limited to the processing of these insurance claims. A copy of this authorization may be used in place of the original. You understand that you are financially responsible for charges not paid by your insurance company. Client/Guardian Initials: _____

Payments: By initialing and signing below; you are confirming that you understand that it is your responsibility for full payment of my fees. Further you understand that ReEvolve,LLC. may submit your claims to your insurance company(ies), if applicable, for direct payment to ReEvolve,LLC. and that if your insurance company does not cover 100% of your bills for services provided that it is your responsibility for full payment of my fees, not your insurance company's.

Further, you confirm that you understand that it is your responsibility to:

• pay, at the time services are rendered, the agreed upon session fee, co-pay, co-insurance, deductible, or any other fees relating to services rendered that are denied or not fully covered by your insurance company(ies);

• provide ReEvolve,LLC. with current mailing address and phone numbers, as well as notification when there are any changes to this information.

• confirm with your insurance company that Garnet J. Nelson, LCSW and any other entity of ReEvolve, LLC. is a participating provider under your specific insurance plan;

• provide ReEvolve,LLC. with appropriate and current insurance information and updates to ensure efficient billing and payment;

• obtain all necessary referrals or authorizations required prior to treatment by ReEvolve,LLC providers. Client/Guardian Initials: _____

Payment schedules for other professional services may be agreed to, if requested.

In circumstances involving unusual financial hardship, I may be willing to negotiate a payment installment plan. If your account has remained unpaid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure payment This may involve submitting the account to a collection agency or filing a claim in small claims court, either of which will require that otherwise confidential information be disclosed for the purposes of collecting payment. Client/Guardian Initials: _____

Returned Check Fee: A $35.00 fee will be assessed for each returned check

Client Discharge / Collection Fees: In the event of failure to pay for services rendered, you understand that you may be discharged from the services of ReEvolve,LLC. until such time as your account is fully paid. Additionally, you understand that you may be referred to a collections agency for non-payment of fees due for services rendered by *Garnet J. Nelson, LCSW or any other entity of ReEvolve, LLC.* You understand that you will be responsible for all collection fees, all agency and attorney fees and costs associated with the collection process (such as court costs), and that these fees and costs will be added to your account balance. You understand that you will be responsible for paying the entire amount of your balance due ***in addition*** to any collection fees. Further, you understand that your personal health information will be revealed in these efforts to collect payment of monies owed. Client/Guardian Initials: _____

CONTACTING ME

I am often not immediately available by telephone; specifically, I will not answer the phone when I am with a client. When I am unavailable, my telephone is answered by a confidential voice mail that

I monitor frequently. I will make every effort to return your call within 24 hours, with the exception of weekends and holidays. If you are unable to reach me and feel that you can't wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist [psychiatrist] on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

MINORS

If you are under eighteen years of age, please be aware that the law may provide your parents the right to examine your treatment records. It is my policy to request an agreement from parents that they waive access to your records. If they agree, I will provide them only with general information about our work together, unless I feel there is a high risk that you will seriously harm yourself or someone else. In this case, I will notify them of my concern. I will also provide them with a summary of your treatment when it is complete. Before giving them any information, I will discuss the matter with you, if possible, and do my best to handle any objections you may have with what I am prepared to discuss.

CONFIDENTIALITY

In general, the privacy of all communications between a client and a license clinical social worker is protected by law, and I can only release information about our work to others with your written permission. However, State law dictates some limits on your privacy of which you should be aware.

Exceptions to your privacy include the following:

• In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order my testimony if he/she determines that the issues demand it.

• There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about your treatment. For example, if I believe that a child, elderly, or disabled person is being abused, I must file a report with the appropriate state agency.

• If I believe that you are threatening serious bodily harm to another, I am required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for you.

• If you threaten to harm to yourself, I may be obligated to seek hospitalization for you or to contact family members or others who can help provide protection. These situations have rarely occurred in my practice. If a similar situation occurs, I will make every effort to fully discuss it with you

before taking any action. I may occasionally find it helpful to consult other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my client. The consultant is also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together.

Additionally, when I am away from my office I will have a trusted colleague "cover" for me. That person will be available for emergencies and thus may need to know about my clients.

Your signature below indicates that you have read this entire agreement and agree to its terms.

_____ _____

Client/Guardian Date

_____ _____

Client/Guardian Date

_____ _____

ReEvolve, LLC Staff