



1058 S. 10th St., Noblesville, IN 46040
(317)754-0808
www.TCC-Indy.com

PRACTICE POLICIES


SESSION LENGTH & PROFESSIONAL FEES: Initial sessions are scheduled for 65 minutes at a rate of \$100. All subsequent appointments are 50 minutes in length at a rate of \$80. Drug and alcohol assessments are scheduled for 90 minutes at a rate of \$200 which includes a detailed report with recommendations. Sessions begin and end on time. It is understandable that occasionally you may be late. If you are late to your session, please understand that the session will not extend past the 50 minutes, nor will the time be added to future sessions.

APPOINTMENTS AND CANCELLATIONS: Cancellations must be made at least 24 hours in advance. Your session time has been reserved exclusively for you and it is unlikely to be filled with another patient in the event you cancel. **Canceling with less than 24 hours notice will result in being charged the full session fee.**

NO SHOWS: If you do not show-up for a session, you will be charged the full session fee.

ONGOING CANCELLATIONS OR MULTIPLE NO-SHOWS: It is understandable that you may occasionally need to cancel or miss an appointment due to illness or emergency. However, your appointment time has been reserved especially for you. Frequent cancellations, or missed appointments could result in the need to discontinue your treatment.

SESSION PAYMENTS: Professional fees may be paid via cash, check, credit card, or debit card and are **due at the time of service**. If you plan to pay by credit or debit card, please complete the **Credit Card Information Form**. Your card information will be stored in our password protected, encrypted system. I charge patients on the day of their session.



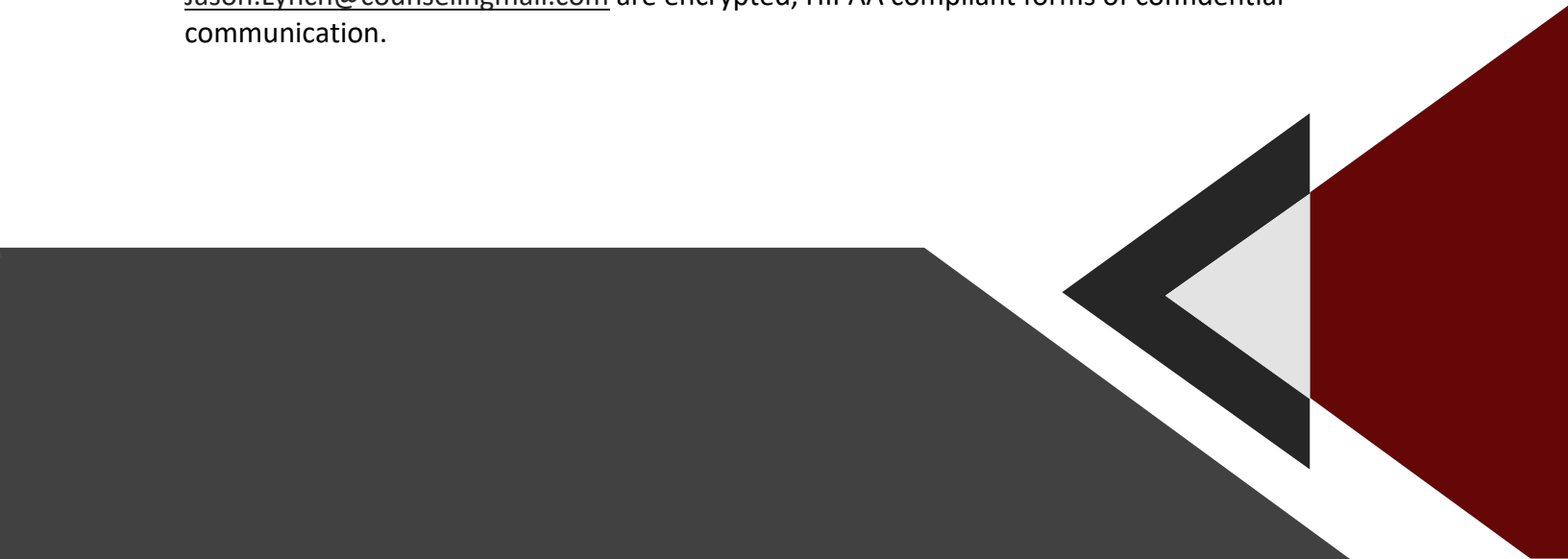
If you prefer to pay by cash, please bring the exact amount with you. I am unable to make change. A \$40.00 bank service charge will be assessed for any returned checks. **I do not “carry over” session balances from week-to-week or extend credit** as this could constitute an unethical dual relationship. Please be prepared to pay the entire balance each week.


INSURANCE: I do not accept insurance for professional services. I can provide you with receipts documenting your out-of-pocket costs if you wish to try and seek reimbursement from your insurance company at a later date.

TELEPHONE ACCESSIBILITY: If you need to contact me between sessions, please call (317) 754-0808 and leave a detailed message with your call-back number. Calls are usually returned the same day. If you call in the evening, over the weekend, or on a holiday, your call will be returned on the next business day. If appropriate, we may mutually agree to a telephone or web-based teletherapy session. Teletherapy sessions are billed at a pro-rated rate of \$100 per hour and rounded up to the nearest 15 minutes. **In a crisis or emergency situation, please call 911 or go directly to any local emergency room.**

SOCIAL MEDIA AND TELECOMMUNICATION: Due to the importance of your confidentiality and the importance of minimizing dual relationships, I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc). I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet and we can talk more about it.

ELECTRONIC COMMUNICATION: We cannot ensure the confidentiality of communication through certain electronic media such as text messages. Therefore, I will not use text messaging to communicate with you. Messages sent to you through the Client Portal or via Jason.Lynch@counselingmail.com are encrypted, HIPAA compliant forms of confidential communication.





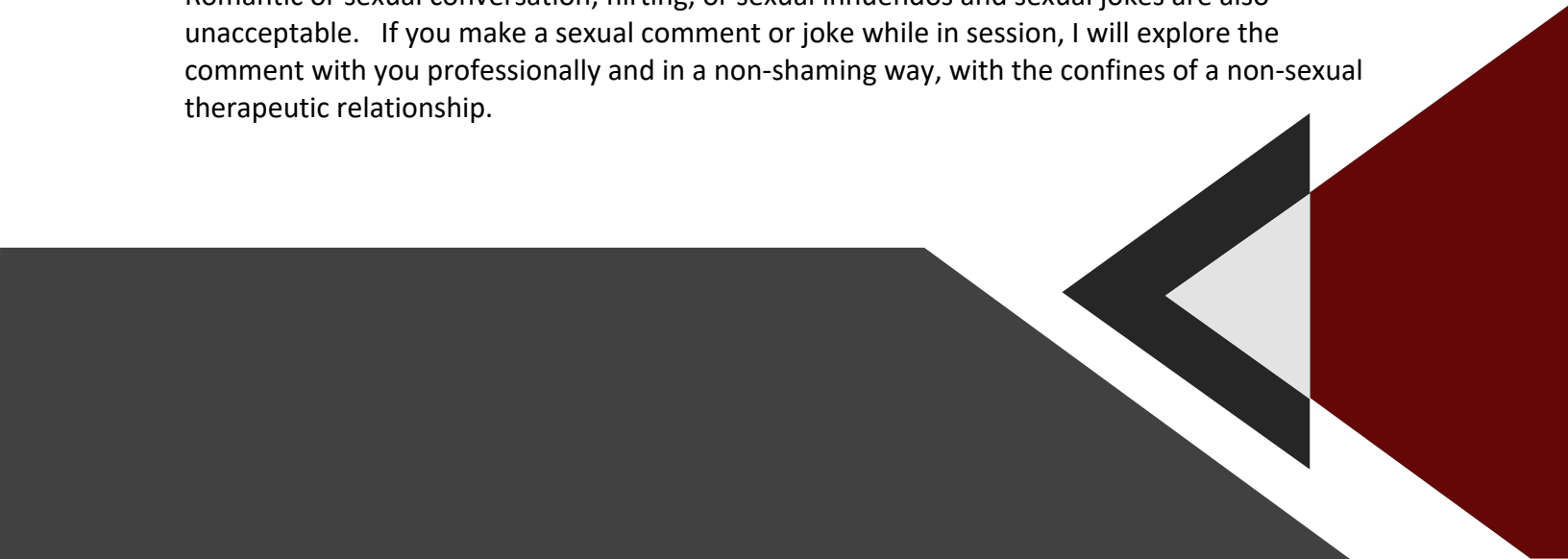
MINORS: If you are a minor, your parents may be legally entitled to information about your treatment. I will discuss with you and your parents what information is appropriate for them to receive and which issues are more appropriately kept confidential.


TERMINATION: Ending relationships can be difficult. Therefore, it is important to have a termination process in order to achieve some closure. The appropriate length of the termination depends on the length and intensity of the treatment. I may terminate treatment after appropriate discussion with you, if I determine that the counseling is not being effectively used, or if you are in default on payment. I will not terminate the therapeutic relationship without first discussing and exploring the reasons and purpose of terminating. If counseling is terminated for any reason, or you request another counselor, I will provide you with a list of qualified counselors to treat you. You may also choose someone on your own or from another referral source.

CONFIDENTIAL ELECTRONIC DATA STORAGE: Your confidentiality as a client is of utmost importance. To secure your clinical information, I use an electronic health record to store and protect your information in a confidential and protected capacity. All client protected health information is covered under the Health Insurance and Portability Act of 1996 and 45 C.F.R., Part 164, Subpart C under HIPAA.

NON-DISCRIMINATION POLICY: The Counseling Center does not discriminate on the basis of race, color, religion (creed), gender, gender expression, age, national origin (ancestry), disability, marital status, sexual orientation, or military status, in any of its activities or operations. We are committed to providing an inclusive and welcoming environment for all clients and visitors.

PHYSICAL CONTACT: Sexual contact is never acceptable in the therapeutic relationship. Romantic or sexual conversation, flirting, or sexual innuendos and sexual jokes are also unacceptable. If you make a sexual comment or joke while in session, I will explore the comment with you professionally and in a non-shaming way, with the confines of a non-sexual therapeutic relationship.



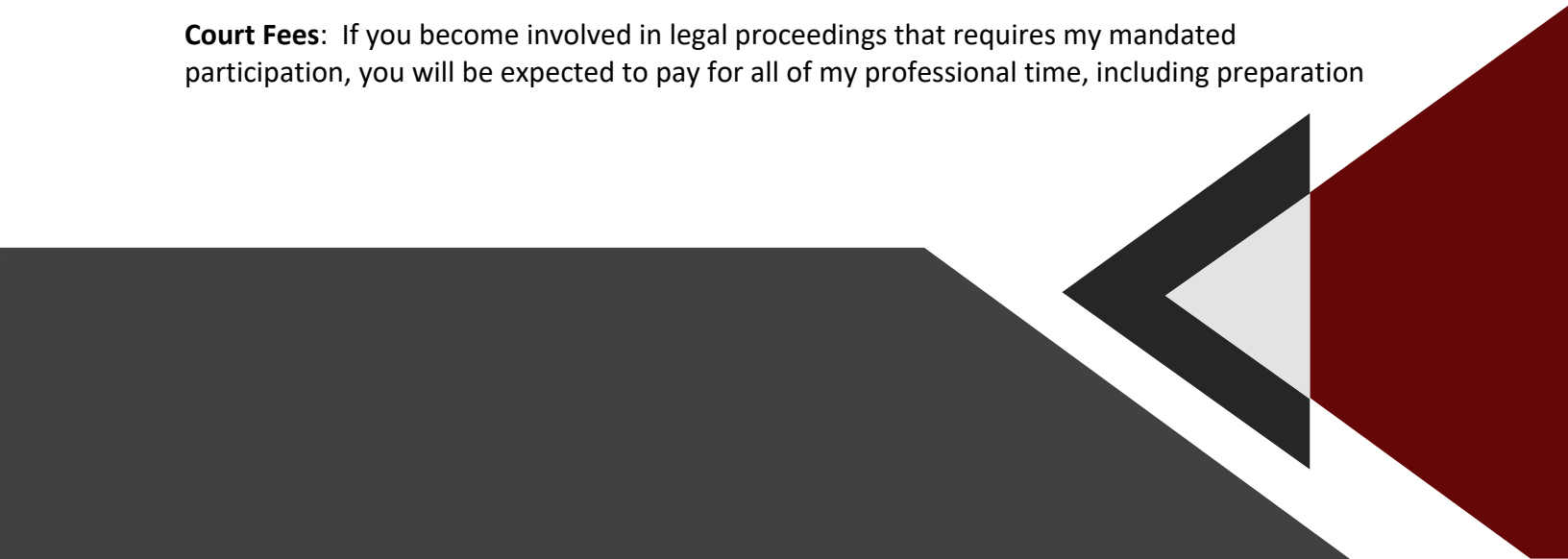



REFERRAL OF FRIENDS, FAMILY, CO-WORKERS: The greatest compliment a counselor can receive is a referral from current or former clients. Please understand that your confidentiality is extremely important. Your counselor will never acknowledge you as a client to other clients, or to anyone outside of The Counseling Center without your written consent, or unless mandated by a court of law.

Court Reports or Letters: I do not write legal letters or court reports on behalf of clients involving divorce, custody, or lawsuits. I do not write letters pertaining to legal matters to any outside person (i.e. doctor, school, attorney, etc.) or agency regarding your treatment. If you are referred for an alcohol and drug assessment, the summary of that assessment along with recommendations will be sent to the referring agency. If a special circumstance arises where a letter is required by court order, it will require your written consent and will be billed to you at \$25.00 per page in addition to my hourly fee (\$100/hour). I reserve the right to refuse to write letters on your behalf (unless court mandated) if I do not feel this would be in your best interest, if it places us in a dual relationship, or it would compromise our therapeutic relationship. If you are involved in a lawsuit, please understand that entering your mental health into a court hearing may not always be in your best interest as it may compromise your confidentiality and your clinical files may be requested. I will not be your advocate in a court hearing or speak on your behalf as that is not the nature of the counselor/client relationship.

Litigation Limitation: Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), neither you (client) nor your attorney, nor anyone else acting on your behalf will call on me to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested. Your signature below indicates that this litigation limitation is clearly understood and agreed to.

Court Fees: If you become involved in legal proceedings that requires my mandated participation, you will be expected to pay for all of my professional time, including preparation







and transportation time and all associated costs (meals, lodging, parking, copies), even if called to testify by another party. Because of the time involved and the interruption to my clinical work, you will be charged \$250 per hour for time out of practice, time for preparation, travel time, and attendance at any legal proceeding on your behalf. Additionally, if other client sessions must be cancelled, these must be covered at the rate of those sessions and will be billed to you.

You agree to pay a retainer fee of \$2,000.00 two weeks prior to the appearance, presentation of records, or testimony requested. Checks will not be considered an acceptable form of payment for these services.

ADDITIONAL RIGHTS AND RESPONSIBILITIES: In addition to your right to confidentiality, you have the right to end your counseling at any time, for whatever reason and without any obligation, with the exception of payment of fees for services already provided. You have the right to question any aspect of your treatment with your counselor. You also have the right to expect that your counselor will maintain professional and ethical boundaries by not entering into other personal, financial, or professional relationships with you.

The Counseling Center reserves the right to discontinue counseling services at any time and for any reason, including, but not limited to, a violation of these Practice Policies, a change or reevaluation by The Counseling Center of your therapeutic needs and The Counseling Center's ability to address those needs, or other circumstances that lead The Counseling Center to conclude in its sole and absolute discretion that your counseling needs would be better served by another practitioner. Under such circumstances, The Counseling Center will suggest an appropriate counselor(s) or counseling agency.





I HAVE THOROUGHLY READ AND FULLY UNDERSTAND THE **PRACTICE POLICIES** DOCUMENT. FURTHERMORE, I AGREE:

1. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR CHARGES AND FEES INCURRED.
2. I AGREE TO HONOR THE 24-HOUR CANCELLATION POLICY.
3. I AGREE TO RESPECT THE BOUNDARIES OF CONTACT BETWEEN SESSIONS AND UNDERSTAND EMAIL AND TEXT IS NOT AN APPROPRIATE WAY TO PROCESS WHAT SHOULD BE DISCUSSED IN SESSION.
4. I UNDERSTAND AND AGREE TO THE SOCIAL MEDIA POLICY.
5. I HAVE HAD ALL QUESTIONS ABOUT THIS DOCUMENT ANSWERED AND SIGN IT WILLINGLY.
6. I AUTHORIZE MY COUNSELOR WITH THE COUNSELING CENTER TO PROVIDE COUNSELING SERVICES TO ME, THE CLIENT, BY SIGNING BELOW.

I AGREE THAT CLICKING ON THE CHECKBOX BELOW CONSTITUTES MY LEGAL SIGNATURE AND THAT I HAVE BEEN PROVIDED A COPY OF THE *PRACTICE POLICIES*, AND THAT I AGREE TO ALL OF THE TERMS AND CONDITIONS CONTAINED HEREIN. IF I HAVE QUESTIONS, THE INFORMATION HAS BEEN EXPLAINED AND/OR SUMMARIZED FOR ME.

Effective Date: 6/30/19
Next Review: 6/30/20
Approved: Jason M. Lynch, MS, LMHCA, ADS

