

Carolyn Wolfe, LMFT, LLC
105 N Virginia Ave #305
Falls Church, Va 22046
Telephone: (703) 405-9451

COUNSELING AGREEMENT CONTRACT

I have set forth below the policies under which I operate my practice. Please read it carefully and feel free to ask any questions. Please sign the agreement and return it at our next meeting.

Client Consent to Treatment

Participating in therapy can result in a number of benefits to you and/or your child, including developing insight, reducing emotional distress, and resolving specific behavioral and emotional concerns. Benefits may also include increased social skills, increased capacity for intimacy, a decrease in negative thoughts and behaviors, and improved ability to achieve personal goals. Psychotherapy requires your active participation and openness. You are encouraged to give feedback and input about the course of therapy as it proceeds. While success cannot be guaranteed, therapist and client can work together to meet the goals of the client.

Over the first several sessions, a specific treatment plan, including goals, techniques, and frequency of visits will be discussed with you. You may ask at any time about alternative treatments and their potential benefits. Occasionally I consult with other professionals regarding the treatment of my clients in order to increase the effectiveness of services. In this case, client names or identifying information are never mentioned in order to protect confidentiality. If at any time I believe I am not able to help you reach your therapeutic goals, I will discuss this with you, and if appropriate, develop a plan for termination and referral to another provider. You have the right to terminate treatment at any time.

Therapy never involves social, sexual or business relationships or any dual relationship that may impair the effectiveness of treatment.

Phone and Emergency Contact

If you need to contact me by phone, please do not hesitate. When I am not available, my voice mail will take your message. I am usually able to return all calls within one business day. You will not be charged for a telephone consultation of 10 minutes or less.

Consultations lasting longer than 10 minutes will be billed at my pro-rated hourly rate in

15-minute intervals and will be indicated as such on your bill. If you cannot reach me in an emergency, please contact your local emergency number, or go directly to the nearest hospital emergency room and ask for the psychiatrist on-staff.

Confidentiality/Release of Information/Informed Consent

Confidentiality is an important and necessary part of good therapy. For most people, knowing that what they say will be kept private or confidential helps them feel more comfortable in sharing their concerns, and to develop trust in their therapist. It is my hope that you will develop a comfort level in openly discussing with me any important issue affecting your life, so I can provide you with the best and most effective care.

As a general practice, I will keep information you share in therapy confidential unless you have given expressed written consent to disclose certain information. In such cases, you will be given a Release of Information Form in which clear parameters will be set for the disclosure of any confidential information. In order to provide the best overall treatment, I value collaboration with other professionals or treatment agencies with which you may be involved. In this instance, you will be asked to sign a separate Release of Information Form for each professional/agency with whom you would like me to exchange information. You may revoke the Release of Information at any time.

There are important exceptions to confidentiality that are important for you to understand before you share information with me in session. All exceptions to confidentiality are clearly outlined in the Informed Consent for Treatment. You will have an opportunity to read, and ask questions about the exceptions to confidentiality before being asked to sign the Informed Consent for

Treatment. In all instances where I am required to break confidentiality, I will make every reasonable effort to talk with you and inform you ahead of time.

*Special Note About Confidentiality and Minors: Sometimes minors in therapy may bring up issues that they do not want shared with other adults in their life (i.e. parents, legal guardians, etc.). Please see the Policy of Minors in Treatment below, for further information.

Related Forms: Release of Information, Informed Consent for Treatment

Policy of Minors in Treatment

All clients under eighteen years of age are considered minors, and parent(s)/legal guardian(s) will sign an informed consent for the treatment of all minors. As minors, the law may give parents and legal guardians the right to examine treatment records. My practice encourages and values open communication and a collaborative approach to working with minors. However, confidentiality is vital in helping minors feel safe to explore feelings they may not be comfortable sharing with other adults. With the minor's involvement, I will provide parents/legal guardians with general information about sessions, treatment goals, and progress. Further, I will work with minors on developing a plan for sharing confidential information with parent(s)/legal guardian when appropriate, and beneficial for treatment progress. If at any time I assess that there is a high risk that the minor may seriously harm him/herself or another person, then I will notify parents/legal guardians immediately of the concern.

Related Forms: Release of Information, Informed Consent for Treatment

Fees

Individual, Couple, or Family 90 min session.....	\$340.00
45 Min In-school/home observations or sessions of 60 min.....	\$225.00
Individual, Couple, or Family 45 min session.....	\$170.00
Group Psychotherapy 60 minute session.....	\$ 110.00

In contracting for psychotherapy, you are responsible for the weekly appointment time(s).

Advanced notice of 24 hours prior to a canceled session is required to avoid a full fee charge for that session. Sessions canceled at the last moment due to illness or emergency will not be charged if the client can make up the missed appointment within 10 days. As a courtesy, group psychotherapy members are allowed to miss 2 sessions at no cost during one calendar year. Any absences from group beyond 2 missed sessions will be charged at the full fee in order to maintain the client's space in the group. If report writing, court appearances, or telephone consultations/sessions are requested, I will bill for my time spent at a pro-rated hourly rate. If you become involved in litigation that requires my participation, you will be expected to pay for my time even if I am compelled by another party to testify.

Billing and Payments

I bill for my services on a monthly basis. Payment is expected by the 20th of the month following each monthly billing cycle. In circumstances of unusual financial hardship, I may be willing to negotiate a fee adjustment or installment payment plan.

Late Fee (\$25)

All bills are due the 20th of each month. A \$25.00 late fee will be added for each bill not received by the 20th, and an additional \$25.00 will be charged for each billing cycle a balance remains unpaid.

Insurance Reimbursement

Because you and not your insurance company are responsible for full payment of the fee to which we agree, it is very important that you find out exactly what mental health services your insurance policy covers. If you are uncertain, you can call your plan administrator and inquire. I will provide you with whatever information I can, based on my experience and will be glad to try to assist you in deciphering the information you receive from your carrier.

I will provide you with a bill that will include a clinical diagnosis and standard billing codes used by insurance carriers. Unless we make another explicit arrangement, you are responsible for filing insurance claims.

Physician Contact

Physical and psychological symptoms often interact. I encourage you to seek medical consultation if warranted. In addition, medication may sometimes be helpful for psychological problems. When appropriate, I will arrange a referral for medication evaluation.

Patient Rights

HIPAA provides you with the following rights: to request that I amend your record; to restrict what Protected Health Information (PHI) information is disclosed to others; requests of an accounting of disclosures that have not required your consent; determining the location of which PHI is sent; having complaints you may make about my procedures/policies recorded in your record; requests for copies of this notice and the HIPAA notice form. You have a right to review you PHI, except in limited legal and emergency situations, including situations where releasing the information to you might be harmful to you. In such a case, I may provide records to an appropriate mental health professional of your choice to review with you.

Counseling Agreement Consent

I have read and understood the preceding statements. I have had an opportunity to ask questions about them, and agree to enter a professional relationship with Carolyn Wolfe, LMFT, LLC.

In the event that a person other than yourself is responsible for paying the bill, please have the party read this document and sign. Thank you.

Client: _____

Date: _____