Restorative Counseling Services

ENLIGHTEN. ENCOURAGE. EMPOWER.

Office Policies and Procedures Information

Welcome to our practice! Our goal is to offer you the most appropriate and up to date services in the most professional manner possible. You will be offered services specifically designed to help you. The services may include individual or family therapy. If it appears you will benefit from medication, then you can be referred to an appropriate practitioner who will evaluate your need for medication and will provide brief check-up appointments to monitor your response. Other psychological services such as testing or group therapy may also be recommended. In these situations you will also be provided with a referral to an appropriate practitioner.

Appointments

Appointments are 45 minutes in length. Except in rare emergencies, you will be seen at the time scheduled. Because this time is set-aside just for you, it is important that you keep this appointment. It is understandable that circumstances may necessitate the cancellation of occasional appointments. In these appointments, we ask that you give at least **24 hours** notice of any appointment that you need to cancel. This will allow your time to be offered to another patient. **You will be charged $50 for all appointments missed without 24 hours advance notice, except in the case of genuine emergencies or illness**.

Costs for Services

The fee for your treatment is $120 per hour for individual psychotherapy, and $125 per hour for family psychotherapy. Except for very brief reports or messages, (up to 10 minutes) you will be charged for phone therapy, report writing, or other professional services at the rate of $100 per hour. (Some insurance coverage requires you to pay only a co-pay at your visit. Your co-pay is $_____ per session.) Payment is required at each session. If you are having difficulty paying your bill, a payment schedule can be discussed.

Health Care Insurance

Many health insurance policies cover the services of psychotherapists. Nevertheless, reimbursement varies considerably from policy to policy. Also, most policies have annual deductibles, co-payments, or other benefit limits. **Read your policy carefully and be aware of what is or is not covered. You may wish to call the member services number on the back of your card to find out the details of your coverage.**

Confidentiality

Psychological services are best provided in an atmosphere of trust. You expect your therapist to be honest about your problems and progress. Your role is to be honest about your expectations for services, your compliance with treatment, and any other barriers to treatment.

Because trust is so important, all services are confidential. Everything you say to your therapist remains within the office walls. Nevertheless, psychologists are required to by law make exceptions in narrow circumstances such as when there is child abuse, immediate danger to another person, or other rare circumstances.

Information about your treatment can certainly be shared with another professional or agency if you wish. You will be asked to sign a release of information form to allow us to accomplish this.

Emergencies

Clients with emergencies should contact the clinician on call by calling (248)-838-3161 and following the instructions for urgent situations. In such an emergency your call will be returned as soon as possible. Do not hesitate to call 911 or go to the nearest emergency room if necessary.

Treatment Concerns

We adhere to the codes of ethics of the American Psychological Association and to the State of Michigan statute. Please feel free to discuss any concerns you have about your treatment with your therapist.

Consent to Treatment

I acknowledge that I have received, have read (or have had read to me), and understand the "Policies and Procedures" description about the therapy I am considering. I have had all my questions answered fully.

I do hereby seek and consent to take part in the treatment by the therapist named below. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as the results of treatment or any procedures provided by this therapist.

I am aware that I may stop my treatment with this therapist at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or any have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.)

I know that I must call to cancel an appointment at least 24 hours before the time of the appointment. If I do not cancel or do not show up, I will be charged for that appointment. I understand that I will be responsible for full payment for such sessions, and that my insurance company cannot be billed for them.

I am aware that an agent of my insurance or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive. It may

also be necessary to provide treatment information such as notes or diagnosis to third party payers. I agree to allow the release of any information necessary for third party payment to be remitted if I choose to use my insurance. I also understand that if payment for the services I receive here is not made, the therapist may stop my treatment.

I am aware that I am fully responsible for payment for treatment I receive, regardless of the determination of insurance company eligibility. I further understand that my therapist can employ the services of a collection agency to retrieve any monies I owe after a reasonable attempt has been made to request payment.

My signature below shows that I understand and agree with all of these statements.

_____ _____

Client Signature (or person acting for client) Date

The therapist has discussed the issues above with the client (and/or his or her parent, guardian or representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____

Signature of Therapist Date