AGREEMENT FOR SERVICE

OUR PURPOSE is to provide excellence of service to each of our clients. Some of our therapist's are licensed and some are unlicensed. These therapists are working under a licensed Marriage Family and Child Therapists; Sherry Douden MFT, # 42531. The success of therapy does not just depend on the skill of the therapist, many other factors, such as the client's openness to working with difficult material, help to determine the outcome of therapy. If you have any questions about your fee or other matters, please discuss these with your therapist.

YOUR APPOINTMENT TIME reserves a psychotherapist's time for you. Missed sessions will be billed a $50.00 fee unless the appointment has been canceled 24 hours in advance of the scheduled time. A missed session will not be rescheduled automatically. You must call to reinstate appointments, or mention that you wish to re-schedule another appointment.

FEE PAYMENTS are presented ahead of the session, unless prior arrangements are made with the therapist. Also, there are additional charges for psychological testing and for copying of records.

THE USUAL AND CUSTOMARY FEE for a psychotherapy session is set on a sliding fee scale and will be determined in your first session. Clients who are unable to pay this rate should discuss their financial situation with the therapist. Group therapy sessions have rates that vary with the type of group. Phone sessions will be billed at your normal psychotherapy rate. Mediation and court appearances will be billed at the rate of $100.00 per hour, regardless of your established fee for psychotherapy. Letters will be billed at your psychotherapy fee for hour(s) spent in preparation. All court fees will be billed at customary rate.

If ICG is a contracted provider, as a courtesy we will bill your insurance company appropriately. For other non-contracted insurance, ICG will provide a super bill to be submitted by the client. It is the responsibility of the client to submit the necessary forms to the third party to seek reimbursement of fees already paid**. Client is financially responsible for all sessions regardless of insurance outcome.** **CLIENT INITIAL_____**

CONFIDENTIALITY is a basic policy. Information and records regarding our clients are kept confidential unless a signed, written consent form is obtained to release records. Such records are the sole property of Insights Counseling Group unless a signed, written consent form is obtained to release records. Therapist reserves the right under California law to provide client with a treatment summary in lieu of actual records. Exceptions to confidentiality, include, but are not limited to reporting child, elder and dependent adult abuse, when a patient makes a serious threat of violence towards a reasonably identifiable victim, or when a patient is dangerous to him/herself or the person or property of another. As a result, we have a no secrets policy. By signing this form, you are giving your permission to the therapist to share with either partner anything communicated to the therapist by the other partner at the therapist's discretion. Third party communication such as text and email, Facebook, Facetime, and Skype are subject to breech in confidentiality. **Client agrees to which type of communication: _____**

BY SIGNING BELOW, CLIENT ACKNOWLEDGES THAT HE/SHE HAS REVIEWED AND FULLY UNDERSTANDS THE TERMS AND CONDITIONS OF THIS AGREEMENT. CLIENT HAS DISCUSSED SUCH TERMS AND CONDITIONS WITH THERAPIST, AND HAS HAD ANY QUESTIONS WITH REGARD TO ITS TERMS AND CONDITIONS ANSWERED TO CLIENTS SATISFACTION. CLIENT AGREES TO HOLD THERAPIST FREE AND HARMLESS FROM ANY CLAIMS, DEMANDS, OR SUITS FOR DAMAGES FROM ANY INJURY OR CONPLICATIONS WHATSOEVER, SAVE NEGLIGENCE, THAT MAY RESULT FROM SUCH TREATMENT.

Client Signature _____Therapist Signature/ Date _____

Approved _____ (pending authorization) _____ Co-pay amount_____

265 Nevada Station, Auburn, California, 95603
(530) 887-1300 www.InsightsCounselingGroup.org