Meredith Counseling and Consulting, LLC
Client-Counselor Service Agreement and Informed Consent

Thank you for choosing Meredith Counseling and Consulting, LLC where we are dedicated to our mission of, ***"Empowering individuals to recognize their worth and live an authentic, purpose-driven, and joyful life."*** We realize that starting counseling is a major decision and you may have many questions. This document is intended to inform you of our policies, state and federal laws and your rights. Although these documents are long and sometimes complex, it is very important that you understand them.

As a client in counseling, you have certain rights and responsibilities. There are also legal limitations to those rights that you should be aware. Moreover, your therapist has corresponding responsibilities to you. These rights and responsibilities are described in the following sections.

CONFIDENTIALITY: Our policies about confidentiality as well as other information about your privacy rights are fully described in a separate document entitled, ***Notice of Privacy Practices***. We will make every effort to keep your personal information private though there are some limitations to confidentiality which you need to be aware:

1) If you wish to have information released to a third party, you may sign a consent form which enables us to release information from your case record.
2) Your counselor may consult with a colleague or other professional counselor in order to give you the best service. In the event that your counselor consults with another counselor, no identifying information such as your full name will be released.
3) Counselors are required by law to release information when a client poses a risk to themselves or others.
4) Counselors are also mandated to report information that you reveal about physical or sexual abuse to children.
5) If your counselor receives a court order or subpoena, he/she may be required to release some information. In such a case, your counselor will consult with other professionals and limit the release to only what is necessary by law.
6) Most insurance companies require you to authorize us to provide them with a clinical diagnosis (dx). By signing this Agreement, you agree that we can provide requested information (dx, progress and attendance) to your carrier if you plan to pay with insurance.
7) Information shared with a doctor (if necessary and with your permission).

APPOINTMENTS: The initial session will be 60-90 minutes in duration and will involve a comprehensive evaluation of your needs. By the end of the evaluation, our therapist will be able to offer you some initial impressions of what our work may include.

Subsequent sessions are typically 45-55 minutes, once per week at a time that you and your therapist mutually agree, although some sessions may be more or less frequent as needed. A treatment plan identifying goals and objectives will be formulated within 14 days of the initial

evaluation session. We believe that the client sets the course of treatment and it is our job to assist you in achieving your goals.

If you need to cancel or reschedule an appointment, we ask that you provide us with 24 hours' notice. If you miss a session without cancelling, you will be charged a $50.00 fee for the missed appointment unless prohibited by the provider contract with your particular insurance carrier.

PARENTS and MINORS: We require parental consent when treating children under 14 years of age. We ask that both the parent and child review and sign this Agreement. However, under PA Act 147, Age of Consent to Mental Health Treatment, juveniles 14-18 years of age can consent to outpatient mental health treatment without parental consent. We cannot release any information to parents with juveniles 14-18 years of age without the minor's written consent.

COORDINATION OF TREATMENT: In order to provide comprehensive services, we make every effort to coordinate care with your physician and/or psychiatrist. If you would like us to send information regarding your treatment, please complete below the name and address of your physician or psychiatrist. Please understand that you have the right to revoke this authorization, in writing, at any time by sending notice. However, a revocation is not valid to the extent that we have acted in reliance on such authorization. If you prefer to decline consent, no information will be shared.

_____ You may inform my physician. _____ I decline the release of information to my physician.

Physician Name: _____

Address: _____

Phone: _____

CONTACTING YOUR THERAPIST: We are often not immediately available by telephone. Our therapists do not answer our phones when we are in session with clients or otherwise unavailable. At these times, you may leave a message on your therapist's confidential voicemail and your call will be returned as soon as possible, usually within 24 hrs, not longer than 48 hrs.

Often it is much easier to communicate short messages such as cancelling or scheduling/rescheduling appointments through text or confidential email. Please ***initial*** below which form of communication, if any. you are comfortable receiving this information:

_____ You may communicate appointment information to me through text messages.

_____ You may communicate appointment information to me through email.

Please note that under no circumstances will therapy be provided through text or email.

EMERGENCY SITUATIONS: If, for any number of unseen reasons, you do not hear from your counselor or we are unable to reach you and you feel you cannot wait for a return call or if you feel unable to keep yourself safe, please 1) contact the Southwestern Pennsylvania Human Services (SPHS) crisis line at **(1-877-225-3567)**. This number is also indicated when you call your therapist's phone 2) go to your local hospital emergency room or 3) call 911. By signing this agreement, you agree to follow one of the three options provided in case of emergency.

PROFESSIONAL FEES: We will make every effort to determine your payment (deductibles, copay, or coinsurance) from your insurance carrier prior to your initial visit. However, we cannot guarantee the information obtained is accurate until the claim has been submitted and we receive the explanation of payments. We ask that you pay your copay, co-insurance, deductible, or out-of-pocket fee at the end of each session. If you refuse to pay your fee, we reserve the right to submit your debt to a collection agency to secure payment.

Out of Pocket Fee for Service Schedule:

Initial Evaluation 60-90 minutes	$175.00
Individual Counseling 55 minutes	$150.00
Individual Counseling 30 minutes	$110.00
Couples or Family Counseling 55 minutes	$150.00
Missed appt/No show fee	$35.00
Returned check fee	$30.00
Letter in response to a request for records	$40.00
Testifying in court, to appear	$450.00 half day (Four hours) $850.00 full day (Over four hours)

CONSENT TO TREATMENT: Your signature below indicates that you have read and reviewed with your therapist pages one, two and three of this Agreement and agree to its terms. Your signature below also indicates that you received a copy of the Notice of Privacy Practices form.

_____ _____ _____

Signature of Client(s) or Personal Representative Date Time

Printed Name of Client(s) or Personal Representative: _____

_____ _____

Signature of Therapist Date

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