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NEW CLIENT PSYCHOTHERAPY POLICY

The following information is intended to clarify our arrangement for working together. Please read, sign and return to me by our second session. If you have any questions, feel free to ask when we next meet.

Beginning Therapy: It is important to choose a therapist who you trust, listens, understands, and can offer you the kind of help you're seeking. For this reason, you are invited to interview me and ask any questions you may have to help you determine if we have a good match for working together, including my clinical training, credentials, professional experience, therapeutic orientation, methods and techniques. I'll also be interested to hear more about your concerns and what has led you to seek professional help. In addition, we can discuss how to best set appropriate goals for working together, including the expected duration of the counseling to best meet your goals.

Initial Interview: Brief (up to 20 minutes) phone contact is welcomed at no charge. In office or video (Zoom/Facetime) sessions scheduled will be billed as a regular session.

Fees/Payment: $175.00/hour for individual, couples or family therapy. Credit cards, checks or cash accepted and due in full at the time of your scheduled appointment. Other online payments (Paypal, Venmo, etc.) may also be accepted. Consultations or therapeutic phone calls longer than ten minutes will be prorated accordingly. Additional traveling fees may be charged for out of office visits. You are responsible for returned bank check or other non payment fees. A late payment fee of 2% interest compounded monthly will be added to balances remaining unpaid after 30 days. Collection procedures may be initiated after a 60-day period where no attempt or agreement is made to pay off balance otherwise. Any exceptions to the policy above must be discussed and agreed to beforehand.

Cancellations/Missed Appointments: 24-HOUR NOTICE IS REQUIRED TO CANCEL OR RESCHEDULE APPOINTMENTS WITHOUT PENALTY. Missed appointments are charged at the full session rate. Last minute cancelations within 24 hours are billed at $100.00. Exceptions may be considered for emergency health circumstances or hazardous weather conditions only.

Billing/Insurance: You are responsible for payment in full, regardless of your insurance coverage status. A copy of your insurance card will be needed for me to bill your insurance provider. I will submit claims electronically. You are solely responsible for verifying your insurance coverage benefits, deductibles, restrictions, pre-authorizations, etc. Check with me if you have questions. I'll do my best to assist you, whenever possible.

Communication:

I DO NOT PROVIDE 24 HOUR EMERGENCY CRISIS INTERVENTION. Should immediate help be needed, contact Colorado Crisis Services (24/7) at 844 493-TALK (8255), or text "TALK" to 38255 or visit www.ColoradoCrisisServices.org or Call 911.

The quickest method to reach me is to text my cell phone for brief non urgent communication (i.e. running late, appointment requests or rescheduling, etc.). Confidential messages can also be left on my office landline or cell phone voicemail. I will generally return your call within 24 hours, or on the next business day. Email is less efficient, reliable or confidential. You may send an email, but text or phone is recommended and preferred. If/when I am unavailable for extended periods, my office landline phone outgoing message will provide instructions on who to contact during my absence.

Termination of Therapy: You can elect to discontinue therapy at any time. If you decide to change our plan for meeting, please discuss this with me beforehand. I also reserve the right to discontinue meeting with you at any time if you do not keep agreements with me, including your financial responsibilities.

Modifications:

I have read, understand and agree to the above psychotherapy policy information. I understand that I could be responsible for additional expenses including collection, court or attorney's fees if I do not follow the terms of this contract. I also give permission to release and provide required information necessary for billing my insurance carrier.

_____ _____

PRINT Client's Name Date

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SIGN Client's (or Responsible Party's) Name

(revised 1/1/2023)