HIGGINS COUNSELING SERVICES

OFFICE POLICY FORM

2500 Quantum Lakes Dr,
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Office: (561) 853-1374 Cell: (561) 247-3694
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OFFICE POLICIES

Initial on the line provided for each statement. If client is a minor both Client and Guardian initial and sign.

1. _____ I understand that I am responsible for my children's behavior. I agree not to leave children unattended at this facility for any reason. I understand that supervision for children is not provided before, after, or during my therapy session. I agree to pick up my children immediately after their session.

2. _____ I understand while in therapy sessions, I will not be allowed to harm myself, others, or any property. If I become a threat of harm to any of these, the authorities will be notified immediately and I will be held responsible for any damages incurred.

3. _____ I am aware that Higgins Counseling Services is not responsible for any items left in the therapy room during or after sessions.

4. _____ I understand that therapist is being supervised by a licensed counselor and that session material may be discussed in the context of supervision, training, and consultation.

5. _____ I agree to give Higgins Counseling Services permission to correspond with me by letter, telephone, or by other means necessary to check on my progress after discharge.

8. _____ I understand that recommendations for nutrition, supplements, exercise, and other healthcare suggestions are not intended to replace medical advice and treatment from your primary care physician.

10. _____ I/We have willingly placed my/ourselves in the program of Higgins Counseling Services and do authorize Higgins Counseling Services to act in my best interests and to perform any treatment that is deemed proper and fit.

11. _____ By means of my/our signature, I/we hereby release Higgins Counseling Services, it's staff from all suit, libel, damages or legal litigation of any kind that could be brought against them for any reason by us on our behalf.

12._____ I understand that Higgins Counseling Services will not get involved in any legal proceedings of any kind including but not limited to custody disputes and divorce proceedings.

13. _____ I/We do also hereby state that this agreement and contract is to be in effect for the life of my/ourselves and that even after death this contract shall stay in effect.

I attest that I have read, reviewed, understood and agreed to abide by all of the above-initialed policies, disclosures, and acknowledgements:

_____ _____

Client name (PRINT) Guardian Name (PRINT)

_____ _____

Signature of Client Date

_____ _____

Signature of Guardian Date

_____

Client Initial

PAYMENT AGREEMENT

(Initial each line item and sign below)

_____ Payment is due at the time of your appointment. Cash and check are acceptable forms of payment.

_____ The standard fee for services is $70 per 50 minute individual, couple or family session (on the phone or in the office). Services are offered at reduced fees based on total household income. (Note: If you'd like to request a reduced fee for services, please complete the Fee Adjustment Request Form with this client intake form).

_____ The agreed upon fee for counseling services is $_____ per 50 minute session.

_____ A fee of $30 will be assessed for a returned check and future payments must be made in cash.

_____ Cancellations require 24 hours notice prior to the time of the appointment. You will be charged the full agreed upon fee (noted above) for cancelling appointments with less than 24 hours notice or for missing appointments without prior notice.

_____ The initial intake session will be dedicated to understanding the client's background and current situation, assessing for immediate risks, evaluating readiness for requested therapy, providing referrals if needed, and establishing treatment goals. There may be no therapeutic counseling or intervention during the initial intake session. The above agreed upon fee for service still applies plus an additional $5 intake-processing fee.

_____ Phone calls in excess of 10 minutes will be billed to the client's account in accordance with the standard session fee.

_____ Treatment may be interrupted or terminated; after 3 unpaid no shows, due to 3 consecutive cancellations, or after unresolved debt of 3 or more sessions.

By initialing each line item above and by signing below, I acknowledge that I understand and commit to the above Payment Agreement and enter into the agreement willingly and voluntarily.

Client Name (please print): _____

Signature of Client or Legal Guardian: _____Date:_____

Signature of Therapist: _____Date:_____