AAIM Counseling

PROFESSIONAL SERVICE CONTRACT

Informed Consent

I understand that my therapist's goal is to provide the best possible service. While I expect benefits from this treatment, I fully understand and accept that because of factors beyond the therapist's control, such benefits and desired outcomes cannot be guaranteed. A variety of treatment methods will be used to provide relief of my symptoms, and to improve coping and problem solving skills.

Fees and Payment:

Out of pocket payer client agreement:

I understand that the initial assessment fee is $120.00, and I understand that the fee is $90.00 for all subsequent 45 minute office visits, which I agree to pay immediately at the time of service. A $5.00 charge will be assessed for any late payments (payments not made at time of the session). I understand that sessions which extend beyond 60 minutes will be pro-rated according to the same fee scale as stated above. Phone calls more than 10 minutes in length, written reports, and other professional contacts will be billed at the same rate. I understand that at least a 24 hour notice for cancellation is required; otherwise I will be charged the full rate for the missed appointment. I understand I may be charged a $10 fee for rescheduling appointments. I will call if I will be greater than 10 minutes late or my appointment may be cancelled.

Ecclesiastical agreement:

I fully understand that I am responsible to pay all charges not for missed appointments and that these "missed appointment" charges will not be charged to my ecclesiastical leader. I understand that the fee billed to my ecclesiastical leader is $_____ for a 45 minute office visit. Phone calls more than 10 minutes in length, written reports, and other professional contacts will be billed at the same rate. I understand that at least a 24 hour notice for cancellation is required; otherwise I will be charged the full rate for the missed appointment. I understand I may be charged a $10 fee for rescheduling appointments. I will call if I will be greater than 10 minutes late or my appointment may be cancelled.

General Agreement:

There will be a $25 service charge to my account for any returned checks. If payment is not made within a reasonable time and reasonable efforts to collect payment is unsuccessful, I understand my account may be turned over to a collection agency. I authorize the release of my identifying information to a collection agency if this becomes necessary. I also agree to pay all collection costs, attorney's fees, court costs and filing fees, including charges or commissions that may be assessed by any individual or

agency retained to pursue collection of any unpaid balance.

Confidentiality:
I understand that my therapist will keep all information about me confidential unless I give my signed consent. However, information will be released without my permission in a medical emergency to save lives, to prevent injury to myself or others, when required by law (for example, suspected child or elderly abuse), or if ordered by the court. I authorize my insurance carrier to pay all policy benefits directly to my therapist and also authorize the release of necessary diagnostic and treatment information to my insurance carrier for myself or my minor child.

Emergencies:
In the event of an emergency I will call the University of Utah Neuropsychiatric Institute at 583-2500 and inform the crisis worker of my emergency. If needed, I will call 911 or go to the nearest hospital emergency room to consult with a crisis worker.

I have read and understand the above information and consent to treatment under the described conditions.

_____ _____
Client Date
and Responsible Party (if client is a minor)

_____ _____
Therapist Date