

COUNSELING - DESCRIPTION OF SERVICES –

Please read carefully through the following information and sign at the bottom. Your goals and expectations are more likely to be met when you understand the nature and limitations of counseling.

Goals and Outcomes:

Generally, counseling is most useful in helping individuals help themselves or improve their relationships by changing feelings, thoughts, and/or behaviors. You determine the nature and amount of change you wish to make.

Benefits and Risks:

Most people experience improvement or resolution to the concerns that brought them to counseling, but of course, there are no guarantees; and there are some risks. For example, counseling could open up new levels of awareness that may cause discomfort.

Length of Therapy:

An estimate on the length of therapy can be provided after the assessment is completed.

Methods of Contact:

On occasion, there may be a need to have contact outside of the normal 50 minute session. For your convenience you can contact us through email or phone. In order to protect confidentiality we request email only be used to schedule or confirm appointments since it is not a secure way to communicate. The office phone, 813-333-6200, will be answered Monday thru Friday from 9:00 am to 5:00 pm. Messages will be returned within 24 hours during the work week. If phone calls last over 15 minutes you will be charged a quarter of the current hourly fee for each additional 15 minutes. If you have an emergency after hours or on the weekend call 911 or the crisis hotline number at 1-800-273-8255.

Confidentiality

I understand that the information you share in counseling can be very personal and that you may not want me to disclose this information to others without your authorization. All clients will be asked to sign an *Authorization for Release of Confidential Information*. I will not release confidential information without this written authorization, unless such release is otherwise authorized or required by law. For example, the law may require us to disclose confidential information if there is reason to believe that a child has been abused or neglected, or that you may be in immediate danger of harming yourself or others. For additional details on how your information may be used and your rights to your health care information please refer to the *Notice of Privacy Practices* form.

Payment for Services

The fee for services is \$105 per 50-minute session. Additional time will be charged in one-half hour increments. Payments are to be made immediately following each session. We only accept cash and checks. If there is a returned check, the charge will be \$25. When requested, we can assist you in seeking reimbursement from your insurance by providing you with the necessary information. If you indicate that a third party will be paying for any portion of your bill, an *Authorization for Release of Confidential Information* would need to be signed. This would allow me to contact that individual and share information regarding your billing/payment arrangements. Please be aware that if your outstanding balance exceeds \$105 I will not be able to schedule further appointments until the balance is paid.

Cancellation of Appointment

On occasion, a situation may arise which prevents you from keeping a scheduled appointment with me. Please notify me of cancellations at least *24 hours* in advance of your appointment. Except in emergency situations, you will be personally charged a quarter of the current hourly fee _____ for late cancellations or one-half the current hourly fee _____ for not calling to let us know you are cancelling the appointment. You will personally be billed for late cancellations or no shows not a third party.

Please arrange for small children to remain at home unless specifically asked to bring them as part of family therapy. Children may not be left unattended in the waiting area.

I have read the above information, and understand that I am encouraged to ask questions, and give input regarding the counseling process at anytime. If there is anything in this form that I do not understand, it is my responsibility to seek clarification.

Payment arrangements are as follows: CLIENT PAY: _____ OTHER PAY: \$ _____

Signature

Date

Signature

Date

Oct 2011