



Samaritan Counseling Center Counseling Agreement

Consent for Treatment: I consent to participate in therapy with the therapist who signs this agreement with me. I understand I need to actively participate in the process and be honest about my feelings and actions. I understand I may experience uncomfortable feelings as a part of this process. I have discussed the goals, objectives and methods of my treatment plan with my therapist. I understand this plan may be modified over time. I understand I may discuss the benefits, risks, alternatives, and nature of the treatment to be employed with my therapist when requested. I have the right to be treated with respect and dignity during counseling. I will not be subjected to any verbal, physical, or emotional abuse by anyone on staff. I am aware that I must cancel appointments 24 hours in advance or I will be charged for the full session fee. I am aware I may terminate therapy at any time without consequence, but I will still be responsible for payment for the services I received.

My signature below authorizes the release of information appropriate to the coordination of my care within the Samaritan Counseling Center, and between the Samaritan Counseling Center and other health care providers or physicians.

Confidentiality: I acknowledge Samaritan Counseling Center complies with HIPAA and Illinois State laws regarding confidentiality. I have read the summary of my rights and received the full statement of privacy policies and rights in keeping with HIPAA requirements.

Grievances: If I have a complaint about my service, I will discuss it with my therapist. If that does not resolve the problem, I may contact the Executive Director to further discuss the issue.

Fees for Service: My fee has been discussed and set with my therapist during the first session. The Samaritan Counseling Center has several options to pay for service:

_____ I agree to pay the full fee of \$175 for the first session and \$145 for subsequent sessions.

_____ I will be using insurance that Samaritan Counseling Center has contracted with to provide services (i.e., PPO or managed care). I agree to pay the co-payment of \$_____ as indicated by my insurance company. I understand I am financially responsible for all treatment the insurance company does not pay for.

_____ I will be using Medicare benefits to pay for my counseling. I understand that not all Samaritan counselors are able to accept Medicare reimbursement and I have discussed this with my counselor. I understand I am financially responsible for all treatment that Medicare or other insurance does not pay for. (ABN form)

_____ I require a fee subsidy. I have honestly discussed my financial situation with my therapist and we have agreed to a fee of \$_____ per session, which I will pay at each session. I understand the agency reviews such fees two times per year. I also understand that this fee will be reviewed if my financial situation changes.

_____ I am aware I may pay with cash, check, or credit card. I understand I will be charged \$20 if a check is returned for insufficient funds.

I certify with my signature below that I have read, understand, and agree with the contents of this therapy agreement.

Client(s)

Date

Therapist

STATEMENT OF PARENTAL CONSENT

I _____ give my consent for son/daughter _____

to attend counseling sessions with _____ of the Samaritan Counseling Center.