ALMOND TREE COUNSELING SERVICES
64 Macy Street
Raynham, Massachusetts 02767

Telephone: 774-409-7395
Email: AlmondTreeCS@gmail.com
Web: www.AlmondTreeCS.org

Date:_____

THERAPIST - CLIENT RESPONSIBILITIES

Name: _____

- We are committed to using our professional expertise helping you with whatever problems you bring to counseling or come up during sessions.

- We will together establish your counseling/therapy goals and will clarify these from time to time.

Please read the following carefully and discuss with us any questions you have before signing. You will receive a duplicate copy.

APPOINTMENTS:

- Your appointment time is being reserved for you and is scheduled according to your counseling/therapy needs and appointment availability. Standard appointments are 50 minutes long. Half sessions are 25 minutes long.

TELEPHONE CALLS/AVAILABILITY:

- During normal business hours, staff members of Almond Tree Counseling Services are usually available by telephone. Call the office telephone number: **774-409-7395**. If there is no staff member available, leave a message on the answering machine. We return calls promptly. If you are experiencing a mental health emergency when you call and do not reach us immediately, go to the nearest Hospital Emergency Room.

- When IN SESSION, your counselor may, at times, answer the telephone during your session when a call from a physician's office is expected or if your counselor is aware of a patient to be in crisis. If you wish to have uninterrupted psychotherapy sessions, please speak to us about this and we will be happy to provide them.

CANCELLATIONS:

- You will be charged $ 25.00 for a session you have failed to cancel within **8 (eight) hours** of an appointment unless you cancel due to an unavoidable emergency. This fee will cover the incurred mileage (See our "Cancellation Policy" form.)

COUNSELING AND THERAPY FEES:

Name: _____

- Our fee is $170.00 for the initial Assessment Visit and $150.00 per regular visit. All fees are payable at the beginning of each session, cash or check (payable to: Almond Tree Counseling Services). Arrangements can be made for payment of fee. My fee for collateral visits or consultations (e.g. court, school, medical team) will be discussed prior to providing these services.

- The fee for spiritual and pastoral accompaniment is $90.00 per hour. Arrangements can be made for official pastoral acts, like a wedding, a funeral service, etc. The fee for such an official pastoral act is $350.00. This includes a preliminary visit to make the necessary arrangements and the pastoral act itself. This does not include any third party fees. Payment cash or check (payable to the officiating clergy).

OFFICE COVERAGE:

- If your counselor falls ill or has a professional or personal emergency, we will notify you by phone. If you want to receive an additional e-mail message, please indicate that below.

Please indicate whether you would like to receive an additional e-mail message:

□	□	_____
Yes	No	Please initial

- During vacations, our office will be closed. We can arrange coverage through another therapist, if we determine the need.

STATEMENT REGARDING CONFIDENTIALITY:

Name: _____

► All information shared with me, Hélène L. Miss, MSW, LICSW, is confidential unless a specific release of information is signed by you with the following exceptions:

. . . You express your planned intention of harming yourself or your emotional/mental state is observed by me to put you at risk.

. . . You express that you intend to do bodily harm to another person. (In that event, I am obligated by law to take reasonable precautions to ensure others' safety.)

. . . You share that you have in the past and/or present emotionally, physically or sexually abused a minor.

. . . You are a minor and you share that you are currently or have been physically or sexually abused, or I determine that you are at significant risk.

. . . Your insurance company requests information relative to payment of your claim, or another process is required to collect unpaid fees, or any legal defense is required by your therapist.

. . . I receive a signed order by a judge to testify in court, or to provide records.

. . . You complain of physical symptoms, or you develop any physical symptoms while receiving counseling/therapy. You will be requested to obtain a physical examination to rule out medical basis for symptoms, and allow me to speak with your physician.

. . . You are currently receiving Mental Health Services and/or are taking medication for a mental health condition, or if you need psychiatric care while receiving therapy, or if you have had previous Mental Health Services. You will be requested to permit me to speak with your prescribing physician, therapist or clinic.

► In the above instances, I will take appropriate action to ensure your safety. Otherwise, I may not reveal any information about you without your written permission. When insurance companies require me to submit clinical information about you to authorize additional sessions, I try to complete insurance treatment forms together with you so you will know exactly what is being written/said about you. I have no control over the confidentiality of any information once it is disclosed outside this office. If you have any questions about who has access to your information, please contact others to whom you have authorized information to be released. Check with your insurance company regarding your out-of-network benefits. We will provide you with a suitable receipt for reimbursement.

STATEMENT REGARDING RELEASE OF INFORMATION:

Name: _____

► I understand that I may be asked to sign a Release of Information to permit Hélène L. Miss, MSW, LICSW to speak with my physician(s), and/or provide pertinent medical records. I understand that I have the right to refuse to sign a Release of Information.

Please Initial _____

► I understand that, when applicable, I will be asked to sign a Release of Information to permit Hélène L. Miss, MSW, LICSW to speak with current or previous therapist(s), and/or provide Mental Health Records. I understand that I have the right to refuse to sign a Release of Information.

Please Initial _____

► I understand that if, at any time, Hélène L. Miss, MSW, LICSW determines that I need a different type of psychotherapy care, she will discuss my needs with me and transfer me to another provider.

Please Initial _____

► I give permission to Hélène L. Miss, MSW, LICSW to contact the person who referred me to her, as a courtesy.

Please Initial _____ Yes □ No □

ADDITIONAL FINANCIAL AGREEMENT:

► If a check is returned due to insufficient funds, a reprocessing fee of $35.00 will be charged. Then all future payments will be requested in cash, postal money order or certified bank check.

I have read and understand the above statements on this page and the preceding pages and agree to the conditions stated.

Name in print:_____Signature: _____Date:_____

Therapist: _____ Date: _____