

***PROFESSIONAL SERVICES AGREEMENT***

**WELCOME**

We are pleased you have chosen Sagemont Counseling Center to receive counseling services. Before we start counseling together there are some things you ought to know about the counseling process and about our office. In legal terms, this is called *informed consent*. The following information provides a brief description of our counseling philosophy as well as an explanation regarding the nature of our professional relationship.

**COUNSELOR VALUES**

Each one of our counselors is licensed by the state of Texas and is a highly trained professional in fields such as theology, psychology, counseling, social work, or marriage & family therapy. We consider ourselves to be Christian counselors. As such, in addition to being clinically professional, our counseling approach is Christ-centered and biblically based. While we meet and accept people, where they are, spiritually, we seek to involve God in the therapeutic process. Therefore, one of our primary goals is to encourage people to establish, develop, or enhance a meaningful relationship with Him as they engage in counseling.

**CONFIDENTIALITY POLICY**

Our work together – our conversations, your records, and any information that you give us – is protected by something called legal *privilege*. That means, in most cases, the law protects you from having information about you given to anyone without your knowledge and permission.

We respect your privacy, and we intend to honor your privilege. However, there are some exceptions to your privacy that you should understand:

1. We may disclose information and notify the proper authorities or other appropriate parties if you admit to serious and imminent thoughts of suicide.
2. If someone else’s life is in danger, we may report it to the intended victim and/or the proper authorities.
3. We may disclose your information to the appropriate authorities if we reasonably suspect that you are a possible victim of abuse, neglect, or domestic violence, or the possible victim of other crimes.
4. We are required by law to report any suspicion of child abuse. If we believe that a child is at risk of being abused, has already been abused, or that someone who previously abused children is still a threat, we must report it to Child Protective Services and/or the police.
5. We are obligated by law to report the suspected abuse of an elder person, 65 years or older, or a dependent/disabled adult.
6. While we recognize the therapeutic value of confidentiality and privacy, even with minors, parents/guardians of those clients who are under the age of eighteen, have the legal right to relevant clinical information about their child.
7. If we deem that professional case consultation is required, to better serve you, we may disclose relevant information to our clinical supervisor.
8. If you intend on filing insurance, or utilizing another third-party payer, our office must share certain information with them, including (but not necessarily limited to) a diagnosis and the times of your visits. If a managed care company is involved with your care, they may require additional information, such as your symptoms and your progress. Therefore, clients who desire strict privacy in this area should consider alternate ways to pay for services.
9. A judge has the power to order us to release information if you are involved in a court case in which our professional relationship is deemed relevant.
10. If you were to file a formal complaint or a malpractice suit, your confidentiality would be waived.

We will disclose your personal information if you sign a written consent that authorizes the release of identified information to a specified recipient. If information in your client file also contains documentation related to a secondary client (i.e. a spouse, parent and/or child, etc.) a release of information form must be signed by each responsible party.

Written records of client communications are stored in a way that protects confidentiality and privacy rights, and electronically stored records are protected by password restrictions, backup systems, virus security software, and firewall protection.

Office personnel may contact you (by telephone, voicemail message, or email, etc.) concerning appointments, or to inform you of other services that may be of interest to you.

**YOUR RIGHTS**

1. A federal program called the Health Insurance Portability and Accountability Act of 1996 (HIPAA) gives you the right to put into writing any request you believe is necessary to restrict the possible misuse of your protected health information. All requests will be honored except as the law specifically outlines the use of your personal health information for treatment, payment and healthcare operations.
2. HIPAA states once you give your consent for the use of your personal information for treatment, payment and healthcare operations by signing the Professional Services Agreement, you may revoke the consent in writing at any time, except to the extent that we have acted based upon your prior consent. If we believe we cannot honor your written request for restriction of healthcare information, we will discuss our reasons with you, and if necessary, terminate our professional agreement formally in writing.
3. Under HIPAA you have the right to request in writing, receive and inspect copies of your protected health information held in this office. HIPAA has guidelines regarding what information must be included in response to your request. If the information you request is outside those guidelines, we have the right to deny your request. Requests within the guidelines will be honored; however, there is a reasonable charge for labor and copying charges. **This includes a $25 charge for labor and copying.** Areasonable time for preparation is required.
4. You have the right to amend any of your protected health information by a written request. If your request is outside the guidelines of the law, we have the right to deny your request to amend records.

If you believe we do not adhere to the stated intentions described in this document, and/or you believe your right to confidentiality has been violated, please talk with your counselor or the Center’s Director, Mike Schumacher, LPC-S, LMFT.

We will take your concerns seriously. If there is no resolution, you may file a complaint with the Department of Health and Human Services, Office of Civil Rights.

**FEES**

Typically, an individual, marital or family counseling appointment will last fifty minutes. Counseling sessions are held at the Counseling Center. Tele-counseling (phone, FaceTime, Skype, etc.) may be available, if clinically appropriate, and is subject to the fee schedule described below.

Fees vary depending upon whether you are an active member of Sagemont Church.

SAGEMONT MEMBERS – The standard fee for current members of Sagemont Church is $40.00 per hour for each counseling session or phone consultation, payable at the time of service.

NON-SAGEMONT MEMBERS – Clients who are not current members of Sagemont Church will be charged a standard fee of $80 per hour for counseling sessions or phone consultations, payable at the time of service.

Email and/or texting correspondence is subject to the same hourly rates.

If psychological testing is recommended by your counselor, additional fees will apply.

**LEGAL MATTERS**

**If you request that your counselor be involved in consultation or testimony related to a legal issue on your behalf, you will be billed at the rate of $100.00 per hour (charged to your credit card) for all the time spent on your case including phone calls, emails/texts, meetings with your attorney, court appearances, writing reports, copying material, travel, preparation time, etc.**

**Due to lack of the required clinical expertise and credentials, your counselor is not qualified to render child evaluations in matters of divorce, custody disputes or other legal issues related to the assessment of children.**

**FINANCIAL AGREEMENT**

Counseling fees will be established prior to the initial session. Payment is due, in full, at the time of service. We do not bill insurance companies for services rendered. However, if appropriate, we can provide you with the necessary paperwork for you to file a claim with your insurance company. We accept cash, check, American Express, Discover, MasterCard and Visa. Appointments will not be extended beyond any unpaid session, and additional counseling appointments will not be scheduled until payment is received.

**CANCELATION POLICY**

The time scheduled for your session is reserved for you. **If you miss an appointment without canceling, or if you cancel with less than a 24-hour notice, you will incur a fee of $40.00 charged to your credit card.** If you are late for a session, we will use the time remaining, but you will be charged the full rate.

***[Initial here: \_\_\_\_\_\_\_]***

**CONSENT FOR TREATMENT**

You have the right to a clear description of the nature of our professional relationship. You also realize you have treatment options other than those offered through the Sagemont Counseling Center, including no counseling at all, and that no guarantee or assurance has been made to you as to the results that may be obtained from counseling. Sometimes you might even feel a bit worse during the initial phases of the counseling process, as we identify problem areas and generate strategies for healing, change, and growth.

Your signature below verifies that:

1. You have freely elected the counseling services offered by Sagemont Counseling Center in good faith and without duress.
2. You are aware counseling through Sagemont is not a crisis response service. You can reach us during regular office hours (8:30 AM to 5:00 PM – Monday through Friday) by calling (281) 481-7133. After hours, please feel free to leave a voice message. **In the case of a medical emergency or significant crisis, you should proceed to the nearest emergency room.**
3. You have been informed of the published fees for services provided by the Sagemont Counseling Center and have made an individual financial agreement for services rendered to you.
4. In order to help you most efficiently, we may ask your approval to audiotape select counseling sessions. Since your authorization is required, you would be notified prior to any recording.
5. You realize minors will not be counseled without the written consent of their biological parents, or the adult who has been court appointed as managing conservator.
6. You understand you may request access to treatment information contained in your client file, and that this release will be authorized unless it is deemed by your counselor to be clinically inappropriate.
7. You have read this *Professional Services Agreement* and understand it.

If you have any concerns or questions about this *Professional Services Agreement*, please raise them with us at the earliest possible time so that we can resolve them in a manner consistent with your best interests.

Client Signature(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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