

THERAPY AGREEMENT

It is important that you understand your rights and obligations relating to your counseling experience. Carefully reading the information below will help you avoid any subsequent surprises. Please feel free to discuss any questions you have concerning this information with your counselor. Turning Point Counseling is a division of Turning Point Ministries, a non-profit 501(c)(3) Christian organization.

ABOUT YOUR COUNSELOR...

- Your counselor is:
 - Licensed ___ Marriage & Family Counselor ___ Psychologist ___ LCSW
 - Registered ___ MFT/LCSW Intern ___ MFT Trainee ___ Psychological Assistant
- If your counselor is not presently licensed, he/she is under weekly supervision with a licensed supervisor(s).

ABOUT YOUR COUNSELING SESSION...

- Your counseling sessions will be **45-55 minutes**/full session, **25 minutes**/half session: [Ind/Couple/Family/Group]
- Estimated term of therapy is _____ sessions. (This will be determined at your first session).
- The fee** for therapy is \$_____ (full) \$_____ (half) per session.

MEANS OF PAYMENT:

\$_____ Cash/Check/Credit Card – payment is due at the time service is rendered.

***I understand that I will be responsible for billing my own insurance company.**

\$_____ OTHER: (i.e. my Church will supplement—Church Name _____)

- On occasion your counselor may deem it necessary to utilize particular **testing instruments** to expedite and enhance the quality of treatment. An additional fee will be charged for each test administered.
- APPOINTMENTS MUST BE CANCELED 24 HOURS IN ADVANCE. OTHERWISE A FULL SESSION CHARGE WILL BE MADE DIRECTLY TO THE CLIENT.** A telephone answering service is available for after-hours messages. Ask you counselor for their private voicemail extension.
- Telephone conversations with your counselor exceeding 5 minutes will be billed in 15 minute increments. All calls are time and date stamped.
- Audio or video taping** of your sessions will be conducted on occasion, if you are seeing a pre-licensed counselor. Tapes will be used for supervision purposes only and then erased. This is to ensure the quality of service you deserve.
- As a training clinic, a **co-counselor** will work with your therapist on occasion.
- In the case that a progress report is required, a minimum of a 2 week notice is required and up to a maximum of 4 weeks for delivery of report. It is the client's responsibility to notify therapist 2 weeks prior to due dates.
- *Payment is required at the time services are rendered. Insurance reimbursement is solely the responsibility of the client. Your therapist will give you a coded receipt and may assist you in filling your claim form. TPC cannot and will not take responsibility for your relationship with your insurance carrier and their reimbursement to you.
- According to California laws any kind of sexual contact, or asking for sexual contact, or **sexual misconduct** by a psychotherapist with a client is illegal, as well as unethical (Business & Professional Code Section 726, 728, and 498 (k)).

ABOUT YOUR FINANCIAL RESPONSIBILITIES...

- I, the undersigned, hereby understand that payment of each session is due at the close of each session unless other arrangements are agreed upon in writing. In the event that credit arrangements have not been agreed upon in writing and the charges have not been paid within 30 days of the due date, I agree that the charges will be subjected to a **late charge of 1.5% per month** on the unpaid balance. The **charge for a returned check is \$30** in addition to the fee owed.
- I, the undersigned, hereby agree that in the event of default in the payment of any amount due, my name and other relevant information may be released by Turning Point Counseling in order to recover such overdue balances.
- I, the undersigned, have read and fully understand the responsibility of this agreement. I have received a copy of this agreement and herein agree to abide by all the conditions set forth above.
- I do not want my email address to be added to Turning Point Ministry Group's eMagazine. _____ initial.

Client(s) Signature

Effective Date

Therapist Signature

Effective Date