Sheryl E. Woodhouse, LMFT
23121 Verdugo Dr., Suite 200
Laguna Hills, CA 92653
(949) 212-6228 / (949) 348-6944

COUNSELING CONTRACT

PATIENT AGREEMENT: I agree to attend the scheduled appointments with all designated family members. Regular sessions are 45 minutes in length. We, the undersigned parent(s) or legal guardian(s) of _____, a minor, do hereby consent to counseling services by the above-named counselor. This authorization shall remain in effect until revoked in writing by the undersigned.

APPOINTMENTS: Time is reserved for your therapy session by agreement with you. If you need to cancel or change an appointment time, please give 48 hours advance notice. **Cancellation without 48 hours advance notice will result in you being charged for the session.** Three (3) or more late cancellations or "no shows" may result in termination of treatment. Please help us to serve you better by keeping scheduled appointments. This fee is NOT covered by insurance, so it will be your personal responsibility.

Patient hereby agrees to a No Show or Late Cancellation fees of: $75.00 _____ (patient initials)

CONFIDENTIALITY: My legal and ethical responsibilities require that our sessions remain confidential. As a result, I will only release clinical information to another professional or agency with your written consent. Only necessary or pertinent information will be shared with written authorization. There are some exceptions under which I am required by law to share information with specific outside parties. These situations would include actual or potentially dangerous behavior towards yourself, towards others or in the case of child abuse.

PATIENT AUTHORIZATION: It is with my full understanding and consent that information about my case may be exchanged with Sheryl E. Woodhouse, MFT and her staff in the capacity of providing assessment and referral, billing and collecting fees and offering ancillary recovery services.

STATEMENT OF FINANCIAL ARRANGEMENTS FOR PROFESSIONAL SERVICES RENDERED: Please read this document carefully, for it describes the financial policy of this office. Any exceptions to this policy must be in writing and signed by all parties involved. It is expected that full payment will be made at the time services are rendered, in the form of cash, check or money order. If special arrangements are necessary, these need to be discussed with Sheryl Woodhouse, MFT in advance.

It is understood that you are responsible for any charges made. Payment for all co-payments, co-insurance or deductible is expected at time of service. It is also understood that, if for any reason, the insurance company does not pay the full amount verified, denies any charges for services that are rendered or if the yearly or lifetime maximum amount is exceeded, that any remaining balance will be the full responsibility of the patient. Any services not covered by insurance or done outside of session time, such as, but not limited to, reviews with managed care, consultations, report writing, etc., will be at my regular fee rate. My regular fees are $150 per therapy session (regular sessions are 45 minutes in length).

FINANCE CHARGES: If patient balances are not paid on date of service, finance charges will be applied. Finance charges are <u>not</u> covered by insurance, so it will be your personal responsibility.

RETURNED CHECKS or PAST DUE ACCOUNTS: For checks returned as unpaid by your bank, a $25 service fee will be applied. Overdue accounts will be referred to a collection agency. Legal fees that we pay to secure past due balances will be added to your account.

I am generally available via telephone in case of an urgent or emergency situation which cannot wait until our regular scheduled session. Please remember, I may not be able to return your call immediately. When I am out of town, I will generally have another therapist answering calls for me.

I have completely read, fully understand and agree to the above terms and information. I understand and agree to the Financial Policy.

_____ Dated:_____
Signature of Patient

_____ Dated:_____
Signature of Parent/Legal Guardian