



## **Client-Therapist Service Agreement**

Welcome. This document contains important information about professional services and business policies of Tayat Counseling, LLC. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. When you sign this document, it will also represent an agreement between us.

Therapy is a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. As a client in therapy, you have certain rights and responsibilities that are important for you to understand. There are also legal limitations to those rights that you should be aware of and understand. Your therapist has corresponding responsibilities to you. These rights and responsibilities are described in the following sections.

### **Goals of Therapy**

There can be many goals for the therapeutic relationship. Some of these will be long-term goals such as improving the quality of your life, learning to live with mindfulness and self-actualization. Others may be more immediate goals such as decreasing anxiety and depression symptoms, developing healthy relationships, changing behavior or decreasing/ending drug use. Whatever the goals for therapy, they will be set by the clients according to what they want to work on in therapy.

### **Services and Fees**

Individual clients are charged at \$130 per 50-minute session and \$180 per 80-minute session.

Couples therapy is charged at \$180 per 50-minute session and \$220 per 80-minute session.

You are responsible for paying at the time of your session; missed appointment fees will be charged the date they are incurred. Payment can be made by check, cash or credit card; we accept payment via IvyPay and checks should be made to Tayat Counseling, LLC. If an appointment runs longer, or you need to speak to your provider over the phone, you will be charged for the additional time. The charge will be determined and prorated on the basis of each additional 15 minutes of time (\$45 per 15-minutes).

## INSURANCE:

In order to protect our clients' personal and confidential information, Tayat has chosen not to accept insurance. This allows our clients and us to work together without restrictions imposed by insurance companies as to the number of sessions we may have or the modes of therapy we may use. If you have insurance through a PPO, they may pay for therapy sessions with an out-of-network provider such as Tayat. An insurance receipt can be made available for your convenience in submitting your insurance claim for reimbursement. Additional copies of bills can be made for you on request.

## EMPLOYEE BENEFITS PLANS:

Please check if your Employee Benefits Plan will pay for some of your therapy. Clients are often unaware that their plans may offer mental health benefits and it is not unusual for them to pay for 3-10 sessions.

## COURT APPEARANCES:

Your therapist will not voluntarily participate in litigation (i.e. custody and divorce proceedings) and, if compelled to do so, the party initiating the subpoena shall be responsible for all fees related to preparation, court appearances and dispositions, and time away from office due to the legal action. These fees include an \$150/hourly rate and all attorney fees/costs incurred by the therapist as a result of the legal action. A \$1,000 retainer is required.

## **Missed Appointments**

A missed appointment occupies a significant portion of our professional time and may reflect an issue that we ought to discuss. As importantly, a missed appointment keeps us from someone else in need. **Therefore, except in the case of an acute emergency or illness, we require a 24-hour notice of any cancellation; otherwise, your account will be charged for the visit.**

If our office is closed, leave a message on your therapist's voice mail or text to inform us of your cancellation so the time may be used appropriately. In addition, you are responsible for coming to your session on time; if you are late, your appointment will still need to end on time.

## **Confidentiality**

Your therapist will make every effort to keep your personal information private. If you wish to have information released, you will be required to sign a consent form before such information will be released. There are some limitations to confidentiality to which you need to be aware. Your therapist may consult with a supervisor or other professional counselor in

order to give you the best service and to adhere to practice laws regarding supervision and licensure- no identifying information such as your name would be released. Therapists are required by law to release information when the client poses a risk to themselves or others and in cases of abuse to children or the elderly. If your therapist receives a court order or subpoena, she may be required to release some information. In such a case, your therapist will consult with other professionals and limit the release to only what is necessary by law. In the event that confidentiality cannot be maintained for any of the above-mentioned reasons, your therapist will make every effort to discuss this with you prior to any necessary disclosures.

### **Confidentiality and Technology**

Please be aware that email and text messaging have limits to confidentiality. If you choose to communicate with your therapist in those ways, it is best to limit the information provided or to choose an alternate form of communication such as a telephone call.

SOCIAL MEDIA POLICY: Friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc) will not be accepted by your therapist, as adding clients as friends or contacts on these sites can compromise your confidentiality and privacy.

### **Consent to Participate in Therapy Services**

Your signature below indicates that you have read this Service Agreement and agree to its terms.

Client Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_  
(if applicable)

Therapist Signature \_\_\_\_\_ Date \_\_\_\_\_