OFFICE POLICY AGREEMENT

CONFIDENTIALITY: Counseling sessions are ***confidential.*** Information about sessions or about you will only be s your written permission except:

A. as mandated by law: including, but not limited to, reporting any situation when immediate danger to you or another pe
B. during a civil, criminal or disciplinary action arising from the counseling where the counselor or therapist is a defenda
C. the necessity of this office to instigate collection procedures for unpaid debts.

CRISIS MANAGEMENT: Please call this office if you are feeling mildly depressed. However, if you are severely d suicidal or homicidal, you need to call 911 or proceed to the nearest area hospital ***(emergency room)***. The psychiatrist on call be able to treat you.

CANCELLATIONS: If you need to cancel or reschedule an appointment, please do so ***at least 24 hours in advance*** of yo scheduled appointment time. When an appointment is held for you, the time is not available for others. A fee of **$40.00** may b for late cancellations and missed appointments. I understand that my insurance will **not** pay for missed or late cancelled appoi **also understand that I am responsible for the payment of the missed or late cancelled office visit fee.** _____

SCHEDULING: A regular session shall be no less than 45 minutes, or more than 53 minutes. I will attempt to be on time, l understood that there are emergencies, which may require occasional slight alterations in our appointment time. This office tri accommodate the client as to their work schedule and other responsibilities. Be prepared to schedule your next week's appoin the time of your current appointment. Or, you must call the office to arrange the next week's appointment time no later than th of the week before.

FEES: The fee is **$85.00** per 53 minute session. You are expected to pay your fee at the time services are delivered. I under John D Mayberry, LMFT will make all necessary efforts to collect benefits owed on my behalf by my insurance company. Hc denial of payment by that insurance company to honor my agreement with them does not relieve my obligation to make full p John D Mayberry, LMFT.

I also understand that I am responsible for all fees connected to any collection activity. _____ **(Initials)**

(SIGN) _____ DATE_____
CLIENT SIGNATURE (PARENT/GUARDIAN if client is a minor)

(SIGN) _____ DATE_____
SPOUSE SIGNATURE

(SIGN) _____ DATE_____
WITNESS SIGNATURE

TERMINATION OF THERAPY: Therapy can be terminated by this office for the following reasons:

1.) Failure by the client to make effort to attain therapeutic goals.
2.) Failure to keep scheduled appointments.
3.) Any aggressive act by client.

Therapy can be terminated by the client at any time. However, therapist must be notified by client, in writing or verbally of th to terminate/suspend therapy sessions and their reason(s). Cancellation of scheduled appointment and/or failure to communica this office is not acceptable. Therapeutically, this office is concerned about motivation of termination of therapy, both internal external, and is concerned as to the physical and emotional safety of the client regarding the termination of therapy without pri

STATEMENT REGARDING LEGAL ACTION: The sole function of this office is to provide psychological and ps therapy to the individual and or family members who choose to attend. Support of legal actions taken against other former or c family members is not included in the therapeutic process.

Competent attorneys will advise their clients that any statement by a clinical therapist can be as detrimental as beneficial to the the litigation process.

Should it be necessary for this office to become involved in the legal issues of the client the following fee structure is applicab

Letter/E-mail/Fax to Attorneys/Courts	**$100.00**
Telephone Contact to Attorneys/Courts	**$30.00/15 minutes**
Appearance in Court: Testimony, Depositions, including travel time.	**$100/hour**

*** All fees cash only, payable in advance. I acknowledge that my insurance does not pay for this additional service.**

(SIGN) _____ DATE_____
CLIENT SIGNATURE (PARENT/GUARDIAN if client is a minor)

CONSENT FOR CONFIDENTIALITY OF SESSION WITH MINOR CHILD:

I agree that the content of sessions between the therapist and my minor child, _____, will be con

(SIGN) _____ DATE_____
CLIENT SIGNATURE (PARENT/GUARDIAN if client is a minor)