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COUPLES THERAPY TREATMENT AGREEMENT

Please initial in each box on the left after reading the text to the right:

INITIAL BELOW	
	FEES: The fee per 50-minute session is $_150_____ (except for the first session, which is $_____). This is du at the time of our session in cash, check, or credit card, unless I am billing your insurance, in which case you must pa your copayment and/or deductible at the session.
	CANCELLATION: Sessions are by appointment only. While I hate charging for missed sessions, I do reserve that tim for you. Therefore, you will be charged $___50_ (not just a copayment) for missed sessions or for those cancelle without 24-hour notice, except in medical emergency. Insurance will not pay for missed sessions. Since your time also valuable, if I forget a session, you get one session free.
	INSURANCE: If I am a provider with your plan: I will submit claims for you, but at our session you must pay an copayment or coinsurance or any portion not covered by your plan. There may be a deductible (an amount you w need to pay out of pocket) before your plan begins coverings sessions. If insurance does not pay as expected, yo remain responsible for the balance. You have the right to waive using insurance coverage, if desired. **If I am NOT a provider for your plan:** You will pay me in full at the session. I can give you an invoice if you wish t seek reimbursement from your plan. Many plans do not cover sessions with a provider who is not in their network.
	SECONDARY INSURANCE: It is your responsibility to tell me about all possible insurance plans that might cover m services (ex. if you have Medicare in addition to a secondary policy, or coverage through your work and a fami member's work). If you do not, you may be responsible in full if claims are denied.
	DIAGNOSIS: Please be aware that if you use insurance I will be required to provide a diagnosis on invoices an claims, and coverage may be limited to certain mental conditions that are covered by your plan.
	LIMITS OF MEDICAL COVERAGE: Even if you have insurance coverage for unlimited sessions, health plans ma review treatment for medical necessity, limit length of treatment or frequency of sessions, and request treatment note While I may check coverage for you, you are responsible for verifying and understanding the limits of your coverag Although I am happy to assist your efforts in obtaining insurance reimbursement, I am unable to guarantee whethe your health plan will provide payment for the services provided.
	CONFIDENTIALITY: What you say in therapy, your records, and your attendance are all confidential. Exceptio include when your records are subpoenaed for legal reasons, when reporting is required or allowed by law (e suspected child abuse or neglect, extreme danger to self, suspected elder abuse, or danger to others), when you giv written permission to release information, and other exceptions outlined in my *Notice of Privacy Practices.*
	WHO IS MY CLIENT? When I work with couples, I consider you both to be my client. While I may have to designate one of you as the main client on an insurance claim/invoice or treatment plan, I do not see either one o you as the source of any problems. I know that each person has their part in relationship patterns.
	INDIVIDUAL SESSIONS: During the course of our work, I may see one or both of you individually for one or more sessions. In these sessions, I will not take on the role of individual therapist -- these sessions are simply being done with the goal of furthering your couples work, unless otherwise indicated. If you feel the need for additional individual support, I am happy to refer you to an individual therapist, if needed.

	NO-SECRETS POLICY: There may be times (ex. in an individual session or an email/text) where you might want to reveal something to me that you do not want shared with your partner. However, if I am to effectively serve you as a couple, I cannot hold a secret in this way. Instead, I will urge you to discuss secrets you have shared with me with your partner. If you do not, and in my clinical judgment this secret could be negatively impacting therapy I may feel it necessary to share it in a couples session. Thus, if you feel it necessary to talk about topics you are unwilling to have shared with your partner, you might want to consult an individual therapist. This "no secrets" policy is intended to help me be transparent with both partners at all times, and to avoid being put a situation where I would have to end couples treatment. *(continued)*
INITIAL BELOW	*Treatment Agreement (continued from Page 1)*
	INFORMATION/RECORDS RELEASE: One medical record is kept for the couple, where I keep all session notes (whether for individual, couples, or family sessions) and significant emails, payment records, etc.. If I receive a request for information about treatment or for records, I would be legally and ethically required to get a written release from both members of the couple before releasing information to anyone. This is true even for individual session notes. Exceptions to confidentiality are outlined above under "Confidentiality." If records are subpoenaed, I will always assert the psychotherapist-patient privilege on behalf of both members of the couple.
	LEGAL MATTERS: If you become involved in legal proceedings that require my participation, you agree by signing this Agreement to pay me at my regular full fee for any time I must spend on your case, including but not limited to time spent to appear in court or give depositions, and lost income for sessions I must miss.
	IN AN EMERGENCY: Leave an e-mail and voicemail message, then call my 24-hour answering service at XXX-XXX-XXXX. Tell them it is an emergency. You may also go to the emergency room or dial 911.
	E-MAIL/SOCIAL MEDIA: In general, e-mail is the quickest way to reach me. I use e-mail to arrange/change appointments. I do not do therapy by e-mail or video. When cancelling, please leave BOTH a voicemail and e-mail. Please do not e-mail me information related to your therapy, as e-mail is not completely confidential, and important issues should be reserved for sessions. Be aware that e-mails between us become part of your legal record. I do not accept friend requests or contact requests from clients on social networking sites (Facebook, LinkedIn, etc.) out of concern for your confidentiality and my privacy. It may also blur the boundaries of our therapy relationship.
	REFERRALS/GROUP: A referral to another provider may become necessary if it becomes clear in my opinion that your issues would be better treated by a professional with different expertise. It is unethical for me to practice beyond the level of my competence, education, training, or experience. I am not responsible for the care received from professionals to whom I refer you. Agreements made between you and I do not involve other professionals in the office suite, who each operate independent solo practices, and are not part of a group.
	ENDINGS: If you are unhappy with any aspect of therapy, please don't just leave – I ask that you talk to me to see if we can work it out. Even if we can't, endings usually feel better this way. Of course, you may end therapy at any time and I am happy to assist with referrals. It is my ethical duty to provide therapy only when I feel you are actively participating and benefiting from the sessions. I may end treatment if there have been repeated no-shows, late cancellations or other treatment interruptions.
	PATIENT RIGHTS: You have the right to ask any questions about your treatment or refuse to participate in treatment at any time. This office does not discriminate in the delivery of health care services based on race, ethnicity, national origin, citizenship or immigration status, religion, gender, age, mental or physical disability, medical condition, sexual orientation, medical history, evidence of insurability, or source of payment.
	COMPLAINTS: The _____[name of licensing board] receives and responds to complaints regarding services provided within the scope of practice of _____[license name]. You may contact the Board online at _____, or by calling (XXX) XXX-XXXX.

	PRIVACY PRACTICES: By initialing here and signing below, you acknowledge receipt of my *Notices of Privac Practices, which* provides information about how I may use/disclose your private health information. I encourage yo to read it in full. My *Notice of Privacy* Practices is subject to change. If I change my Notice, I will give you a revise Notice. If you have left treatment, you may obtain the revised notice from me at the above address and phone numbe

PLEASE SIGN IF USING YOUR INSURANCE OR EAP: *"I authorize the release of any information necessary (Including notes, treatment summaries and diagnosis) to process claims, to prove medical necessity for treatment, to request additional sessions, or to comply with treatment reviews or mandated administrative chart reviews from the insurance plan. If my therapist is a network provider, I authorize payment of benefits to be made to him/her."*

(Client #1: Sign here) :**X** _____

(Client #2: Sign here) :**X** _____

By signing below, I acknowledge that I have read and understand the above rights and policies.

X_____	**X**_____	**X**_____
Signature, Client #1	*Printed Name, Client #1*	*Date*
X_____	**X**_____	**X**_____
Signature, Client #2	*Printed Name, Client #2*	*Date*