

CHAGRIN COUNSELING ASSOCIATES & EATING RECOVERY

OFFICE POLICIES

This information sheet has been prepared to acquaint you with the policies affecting issues that frequently arise over the course of treatment. The ethical cannons of our profession demand that we respect the dignity and integrity of those who seek our help regardless of race, religion, gender, ethnicity, age, disability, our source of payment. Your signature on this document will indicate that you have read and understood it, and agree to its provisions. We are willing to discuss our office policies with you at any time.

CONFIDENTIALITY

1. If you are an adult, anything you say in the context of psychotherapy is privileged with these exceptions:
 - A. If you are behaving in a way that poses a threat to the physical well-being of yourself or another person, privilege is waived. We are bound by law to contact the person(s) involved, and warn them of possible danger.
 - B. If a parent or guardian is suspected of child or elder abuse, Ohio State law mandates that the therapist report his/her concern to the appropriate authorities.
 - C. If you are using confidentiality as a means of avoiding legal punishment, privilege is waived.
 - D. Of course, all actions taken under these provisions will be discussed with you fully, and in advance, whenever possible.
2. Parents or guardians of minors are entitled to information communicated by their children in psychotherapy. However, ethics require us to communicate such information only in ways that will be helpful to enhancing family relationships and not jeopardize the relationship between minor and therapist.
3. Regarding divorce or pending divorce, it is the policy of this office that financial responsibility for the account belongs to the parent/guardian initiating treatment.
4. We are often asked to send records to or request records from health care providers. On these occasions, you will be asked to sign a "release of information" form, without which we cannot send records. A fee will be billed for each set of records we send, to cover duplication and postage costs.
5. In this office, the staff is comprised of licensed psychologists, psychology assistants and social workers. Clinical supervision is provided for unlicensed personnel and clients may be discussed with supervisors for training purposes. You have the right to know the professional training and background of our staff members and you have the right to meet the clinical supervisor if you wish.
6. In a group practice such as ours, it is not uncommon for family members to be in treatment with different therapists. The therapists will confer, as needed, to provide continuity of care.

FEES

1. Our standard fee is \$100.00 per 50 minute clinical hour. Please speak with your therapist if a sliding fee is necessary.
2. Payment must be made at the time of session by cash, check, or credit card.
3. We understand that evaluation and treatment can be very expensive and we encourage you to feel free to discuss any aspects of our billing procedures at any time.
4. A charge of \$15.00 will be made on all returned checks. Also, a 1.5% finance charge will be applied to monthly balances on your account in excess of \$200.00. If it becomes necessary to obtain a collection agency to collect funds on an account, a \$25.00 fee will be added.
5. Phone contact made by a client or on behalf of a client that exceeds 15 minutes will be charged at \$25.00 per 15 minute increment.
6. If we are called as an expert or fact witness in a legal case our fee is \$200.00 per hour in court plus travel time and preparation time.
7. Any reports or letters written on behalf of the client will be charged \$100.00 per hour.

OTHER MATTERS

1. We require 24-hour advance notice if you cannot keep an appointment. Otherwise, you will be charged for the missed session. It is our policy to automatically discontinue providing psychotherapy for individuals who cancel or fail to show for 2 appointments in a row.
2. Routine calls for information and appointment scheduling will be handled during the normal workday. Confidential messages may be left on the therapist's personal voice mail at any time during the day or evening.
3. **Should you or a family member be experiencing an emergency please call 911 and proceed to your nearest hospital emergency room.**

I agree and consent to participate in mental health services. I understand that I am consenting and agreeing only to those services that the therapist is qualified to provide within: (1) the scope of the provider's license, certification, and training, or (2) the scope of license, certification, and training of the mental health provider directly supervising the services received by the patient. I understand that no promises have been made to me as to results of treatment of any procedures provided.

If the patient is under the age of eighteen, I attest that I have legal custody of this child and am therefore allowed to initiate and consent for treatment and I agree to assume financial responsibility for this treatment.

Thank you,

Chagrin Counseling Associates & Eating Recovery.

Date_____

Signature_____