ALTERNATIVES FAMILY & COUNSELING SERVICES, PA

PO Box 1323, WEST CALDWELL, NJ 07006 973 228-4664

OFFICE INFORMATION, FEE AGREEMENT AND CONSENT

WELCOME: Thank you for choosing Alternatives Counseling Services. We appreciate the opportunity to provide you with professional services and are confident that your visits will be productive. The information that follows contains important office and procedural information regarding our policies and methods of practice. Please read this carefully and discuss any areas of concern or questions.

REACHING US: Our telephone number is listed above. We do not answer the phone while we are in session or are out of the office. We are diligent about checking voicemail and will make every effort to return calls promptly. Please leave messages regarding scheduling and other routine matters. In case of emergency for established patients only, please text your therapist and/or go to the ER.

OFFICE POLICIES/APPOINTMENTS: Therapy is most effective with people who take an active role in their treatment. This includes being open with their therapist, doing any agreed upon work outside the therapy sessions and being committed to therapy by attending regularly scheduled appointments. Those who get a maximum out of therapy make their appointments a priority, scheduling other events around them when necessary. Please keep in mind that your therapist has set your appointment time aside for you. If you miss your session without giving ample notice it prevents others from scheduling a session in your place. Accordingly, please cancel at least 24 hours in advance if you must cancel or wish to change an appointment and we reserve the right to charge for missed sessions. Insurance companies do not cover missed appointment fees.

FEE AGREEMENT: The initial consultation is $400. Individual, Couples, or Family therapy sessions are $300/45 minutes, $400 1 Hour. If you have and wish to utilize health insurance, please discuss this with your therapist so terms can be arranged. We work with many insurance plans as an out of network provider, and this can significantly offset the cost of treatment. Please understand that final responsibility for account balances always rests with the patient. In the event that an account is defaulted, accounts will be sent to collections and the attorney will be responsible for collection of all outstanding balances and accruing charges. It would then be the patient's responsibility to pay all costs for collections including attorney fees.

CONFIDENTIALITY: Material discussed and documented in the medical record of sessions is confidential. This means that nobody may access it without your (or the parent if the patient is under 16) express consent and authorization. Limits on confidentiality may include the threat of patient suicide, homicide or for suspected child abuse situations where the therapist may be required to go outside the therapy office. Please discuss any questions or concerns regarding this or any other issue with your therapist. Insurance companies often request very personal information from your therapist or medical record to authorize sessions or payment. If treatment plans are requested, they will be written only with you in your session to ensure your consent and participation. There is a fee for copying of records and for written reports done outside of your session time. No court appearances or involvement in legal issues will be entertained by your therapist or Alternatives Counseling.

RESPONSIBILITY: By signing this document, the patient or responsible party agrees that they have carefully read this agreement, have received a copy of it if they wish and agree to the terms including fee agreement, and give consent for psychotherapeutic/ counseling treatment. If you have further questions or wish to discuss billing arrangements please openly discuss this with your therapist in session.

Signature:_____Date:_____