

PSYCHOTHERAPY AGREEMENT

I, _____, agree to meet with Laura Grimes, LCSW, _____ per week and understand that the full fee for sessions is: \$110.00 each individual session or \$125.00 each couples/family session. My sessions will last 50 minutes. **I am aware that any cancellations of appointments must be made more than 24 hours before my appointment, unless it is an emergency and if I do not cancel or not show up, I will be charged for the full fee of that appointment.** I agree to be financially responsible for the cost of treatment and I am aware that if I have not paid for services received or worked out a payment arrangement with Laura Grimes, LCSW, treatment may be discontinued.

Please choose one of the following options by initialing:

_____ I am paying full fee for psychotherapy and am aware that I must bring cash or a check to each appointment unless other arrangements have been made.

_____ I am electing to have my treatment to be paid in full or part by my insurance carrier or another third party, I will authorize this in writing and allow Laura Grimes, LCSW, to release to an authorized agent of my insurance or a third-party payer information about the type(s), cost(s), date(s) of any service of treatment I receive. I am financially responsible for any portion of the fees not covered or reimbursed by my health insurance carrier. Further, I understand that I am responsible for preauthorizing sessions before beginning treatment and if I do not receive preauthorization, I am financially responsible for those sessions not covered by my insurance.

_____ I have discussed the fee with Laura Grimes, LCSW and we have agreed upon _____ per session as my fee.

I have been informed and agree to hold Laura Grimes, LCSW, harmless from any losses, damages, liabilities, costs and expenses (including and without limitation of attorney's fees) arising from the release of such information to my insurance carrier, or to a third-party payer or to any other agent as designated by me.

I am aware that the practice of psychotherapy is not an exact science and so predictions of the effect are not precise or guaranteed. I acknowledge that no guarantees have been made to me regarding the results of treatment provided by Laura Grimes, LCSW.

I understand that regular attendance will produce the maximum benefit, but that I am free to discontinue treatment at any time. If I decide to do so, I will notify Laura Grimes, LCSW, at least two weeks in advance so that effective planning for termination and or continued treatment elsewhere can be implemented. I am aware that I will still be responsible for payment for the services that I received.

I understand that Laura Grimes, LCSW is not providing an emergency service and I have been informed of whom and where I should call upon in an emergency or during weekend, vacations, and evening hours.

I understand that all conversations with Laura Grimes, LCSW, are confidential. I further understand that Laura Grimes, LCSW, by law, must report actual or suspected child or elder abuse/neglect to the appropriate authorities. In addition, Laura Grimes, LCSW, has a legal responsibility to protect anyone if I may threaten harmful or dangerous actions (including those actions to myself) and may break confidentiality of our communication if such a situation arises.

Name (please print): _____

Signature/Date: _____

Parent or Guardian/Date: _____

Witness/Date: _____