NANCY IREY HOLMES, PSY D
Licensed Psychologist
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PROFESSIONAL SERVICE CONTRACT

INFORMATION AND CONSENT TO TREATMENT

Please read the following carefully, initial each item and sign on the last page. If there are any items contained within that you wish to discuss, please bring them to the attention of the counselor.

Therapist:_____

Beginning service date:_____

_____**FEES:** The standard service charge is $225.00 for an initial consultation, $150.00 for a 50 minute office appointment and $225.00/90 minute office appointment. Longer sessions are prorated at the same hourly fee.

Telephone sessions, insurance reports and third party consultations will be billed at the standard rate. Telephone consultations of fewer than fifteen minutes are generally at no cost, unless there is a need for frequent calls. Returned check fee is $20.00.

_____**PAYMENT POLICY:** Payment is due in full at the time of each session. If we have agreed to bill your insurance company, co-payment is due at the time of service. **Please understand that if your insurance company should for any reason decline your claim, the full responsibility of the amount owed will become that of the client.**

_____**FINANCIAL AGREEMENT:**

- Patient Responsibility for Charges: I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I clearly understand and agree that unless I have valid insurance coverage for mental health services, I must pay my entire balance **in full** at each visit.
- Policy on Insurance Coverage: I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I clearly understand and agree that if I do have insurance coverage for Dr. Holmes, I must pay for all copays, co-insurances, deductibles, uncovered services, or denied insurance claims **in full** at each visit. I understand that if my insurance carrier does not pay Dr. Holmes within 60 days of billing, the balance is due **in full** by me. It is my responsibility to see that the insurance carrier makes prompt payment and to handle any disputes or questions that may arise. I agree

that payments will not be delayed or withheld because of any insurance coverage or the pendency of claims thereon.

- Policy on Benefits Quoted: I understand and agree the DR. Holmes cannot guarantee the benefits quoted by any insurance carrier, as the Insurance carrier themselves will not guaranty the quotes that they provide. Any quote Insurance companies provide comes with a disclaimer that final benefits will be determined once claims are received and processed.
- Policy on Nonpayment: I understand that if I do not pay on my account for 60 days, I will be turned over to collections, at which point I will be held responsible for any costs Dr. Holmes incurs in collecting any unpaid balances more than 90 days past due including reasonable attorney fees.

_____**CONFLICT RESOLUTION:** Therapy can evoke strong emotions in people and there may be times where you react to something that is said in session. Your emotions are important to me, and it is an essential part of therapy for us to work out any problems in communication. Therapy is intended to be a non-judgmental, safe place for you to discuss your emotions and your reactions to the world as well as your reactions to our discussion. I ask that you agree to discuss with me anytime you react strongly to something I have said, or if you feel you were not adequately heard. I agree to work with you in getting thru those rough patches as people do outside the therapy room.

_____**CONFIDENTIALITY:** The information that you share in therapy is kept in confidence as protected by federal and state laws. This confidentiality applies to the therapist's work with children, adolescents and adults. If it is necessary to disclose information during the course of therapy or consult with a third party, a written release signed by the client will be obtained prior to the disclosure.

Under certain circumstances the therapist is mandated by law to break confidentiality:

- **Information may be given without your permission if subpoenaed to testify in court.**
- **When statements are made about suicidal or homicidal intentions.**
- **Statements indicating that you have committed or intend to commit acts of child or elder abuse.**
- **Statements made by persons under the age of 18 indicating that abuse is occurring or has occurred, including but not limited to emotional and/or physical abuse, neglect and financial exploitation.**
- **Information that would assist in a medical emergency.**

_____**APPOINTMENTS:** I am dedicated to staying on schedule and seeing clients on time for their appointments. I ask that clients be on time for their scheduled appointments, planning extra time for travel, parking or filling out forms. It is recommended that you arrive 5-10 minutes early.

_____**LATE ARRIVALS:** Clients who arrive more than 10 minutes late for their scheduled appointment, will be rescheduled. Clients who are habitually late or miss appointments may be

rescheduled, however they will be asked to call and reschedule the morning of the day they wish to be seen. At that time they will be given the choice of available appointments for that day.

_____**CANCELLATIONS:** Please give a minimum of 24 hours' notice to cancel a scheduled appointment (unless it is due to a contagious illness or an emergency). If you fail to cancel a scheduled appointment, I cannot use this time for another client. The first time this occurs I charge $50 for a missed appointment and following that the full session fee is directly billed.

WRITTEN AGREEMENT & CONTACT INFORMATION: I have read the above statement and understand my rights and responsibilities. I understand that there can be no absolute guarantee of cure in the practice of therapy. I agree to comply with all of the policies and meet my financial obligations. I understand my rights to confidentiality as well as the limitations. I may receive a copy of this form if I request it. I have read the Agreement and Informed Consent for Treatment and will refer to it for a more complete explanation.

Clients printed name: _____

Client's signature: _____ **Date:** _____

Address: _____
Street address

_____
City **State** **Zip**

Phone Numbers: Home: _____ May we leave a message? ☐yes ☐no

Cell/Other: _____ May we leave a message? ☐yes ☐no

Signature of Parent/Guardian of Minor Child: _____ **Date:** _____

Emergency Contact Person (for emergency use <u>only</u>, not merely to contact you):

Name: _____

Phone: _____