CONTRACT, OFFICE POLICIES, AND FINANCIAL AGREEMENT

Please read and sign two copies. Keep one for your records

Lindsay Fleming, LPC, LLC is a business facility where I engage in the practice of mental and behavioral health services delivery ("counseling").

Statement of Understanding/Informed Consent: Welcome. This information is intended to help you feel as comfortable as possible as you or your child begin psychotherapy. It contains information about my services and summary information about the Health Insurance Portability and Accountability Act (HIPPA), a federal law that provides privacy protection and patient rights with regard to the use and disclosure of Protected Health Information (PHI).

Rights and Risks: As with any treatment, there are some risks as well as benefits with therapy. Risks sometimes include experiencing uncomfortable or painful feelings such as sadness, anxiety, anger, frustration or other feelings. These risks are normal and to be expected when people are making important changes in their life. While you consider these risks, you should also know that therapy has been shown to have many benefits that include significant reduction of distress as well as improved relationships and coping skills, increased self awareness and happiness.

Confidentiality: Information shared will be held in confidence with certain limitations. Information will not be released without your written consent, except for professional consultation with a supervisor(s), which is required by law. Additionally, your therapist is required by law to disclose information pertaining to suspected child or elder abuse or neglect; inability to care for one's basic needs for food, clothing or shelter; and threatened harm to oneself or others. The courts may, in select cases, subpoena counseling records. It is understood that information regarding treatment and diagnosis will be provided to an insurance company if you opt to send in claims to your insurance company for reimbursement. You may want to discuss further limits or exceptions of confidentiality.

Privacy: By signing this contract, I acknowledge receipt of the separate form "Notice of Privacy Practices." I understand Lindsay Fleming, LPC, LLC utilizes a paper/file and an electronic management system to maintain my and/or my child's records. I understand that the file is stored in a locked cabinet at the facility. I understand that the online file has two layers of security codes. I understand that any counseling session in which I participate in may be discussed with a supervisor and is for the purpose of improving my and or my child's care, and not an invasion of my rights of privacy.

Appointments: · All office visits are by appointment with your therapist directly. Please arrive on time, as you use up your own time when you arrive late for an appointment. The usual length of an appointment is between 53-60 minutes. **Late cancellations** (less than 24 hours before) will result in a $50 fee.

No-show appointments are charged $100 to the credit card on file. If your appointment is cancelled or missed, contact your therapist for a new appointment time. Insurance companies will not pay for no-show charges or late cancellation charges or for telephone consultations.

Fees: Lindsay Fleming, LPC, LLC is a self-pay practice. This means that payment for services are required, in full, at the time services are rendered. Your health insurance may help you recover some of your counseling costs. It is your responsibility to contact your insurance company to verify reimbursement for out of network providers. This practice will not communicate with insurance companies directly. This office will not accept responsibility for collecting insurance claims or for negotiating a settlement on a disputed claim.

Payment: There is a $35.00 service fee for checks returned for non-sufficient funds, and the client will be required to pay for future sessions in cash. Whoever (parent, grandparent, nanny, sitter, etc.) accompanies

a minor to his/her appointment is expected to bring payment at the time of the service in full. For separated or divorced parents, payment is expected from the parent bringing the child in for treatment. We will not bill another parent for payments due at time of service. Unaccompanied minors should bring payment for said service or a credit card must be on file for payment at the time of the appointment. Payments can be made in person or by phone.

Our office will provide an "insurance ready" receipt upon request. Clients will receive a statement periodically reflecting any balance due on their account, either in paper copy or via email when we are granted permission to do so. Clients and parents/guardians of minor clients are responsible for full payment on their accounts. Accounts become delinquent after thirty (30) days.

By signing this contract, you acknowledge responsibility for payment per hour for any demand on the therapist's time that occurs under your direction and/or on your behalf. This includes time demands that result from involvement in any legal proceeding. The fees are detailed on page 3.

Our office will provide an "insurance ready" receipt upon request. Clients will receive a statement periodically reflecting any balance due on their account, either in paper copy or via email when we are granted permission to do so. This office will not accept responsibility for sending and/or collecting insurance claims or for negotiating a settlement on a disputed claim. Clients and parents/guardians of minor clients are responsible for payment on their accounts. Accounts become delinquent after thirty (30) days.

Delinquent accounts may be turned over for collection at the responsible party's expense.

CLIENT/RESPONSIBLE PARTY ACKNOWLEDGEMENT AND ACCEPTANCE OF TERMS: Any change in my financial situation I will discuss with my therapist. I have read, understand, and agree to the above policies and the fee schedule on page 3 of this contract. I have discussed these policies with my therapist if desired and all questions are answered to my satisfaction. I have been offered a copy of these policies and understand a copy is available on the practice website. I hereby authorize Lindsay Fleming, LPC, LLC and my therapist to abide by my expressed preferences on the "Payment Form" I submitted with this contract. I understand my reimbursement for services by insurance is a relationship between me and my insurance company and I agree to accept financial responsibility for payment of charges incurred in full. I understand that in the event of non-payment, I will bear the cost of collection and/or court costs and reasonable legal fees should this be required. I understand that fees for all services are not negotiable.

Consent to Treatment and Fee: I hereby agree to full responsibility for all expenses incurred by me and/or on account of this client and hereby assign Lindsay Fleming, LPC, LLC due to me to the full extent of my financial obligation to Lindsay Fleming, LPC, LLC. I have read and/or received a copy of Notice of Privacy Practices Policy. A completed "Payment Form" is required for my file.

FEE SCHEDULE

I acknowledge and understand the fee schedule, detailed in the table below. I understand that I am responsible for all costs for services at the time of service. I understand that it is my responsibility to file a claim with my insurance company for reimbursement.

In the event that I cancel an appointment within 24-hours or fail to attend a scheduled appointment (NO SHOW), I hereby authorize Lindsay Fleming, LPC, LLC to charge to my credit card the appropriate fee.

I understand that that the "ADDITIONAL" portion of the fee schedule is not billable to insurance and will not be paid for by a third party. Any "ADDITIONAL" fees incurred by me or by my dependent child are my sole responsibility.

STANDARD FEES	0-30 Minutes	31-52 Minutes	53-60 Minutes	Flat Fee
Initial Intake Assessment/Interview				$200
Individual Psychotherapy Session	$120	$135	$150	

ADDITIONAL FEES (to be paid by the undersigned)	Fee
Cancel less than 24 hours notice	$50
No Show Fee	$100
Lengthy Phone Calls (Over 15 minutes)	$25 per 15 minutes
Consultation with outside agencies/schools (Phone and In-person)	$150 per hour
Depositions, subpoenas, legal and/or court preparation and proceedings	$300 per hour
Paperwork/Form completion/Letters	$40
Full Progress Report	$150

*Allow 7-10 business days to complete all forms and letters. There is a $10 fee for "rush" requests.

Dismissal from the Practice: If you are "dismissed" or "terminated" from the practice, it means you can no longer schedule appointments or consider us to be your provider. You will have to find another practice for your services. **Common reasons for dismissal:** Failure to keep appointments or frequent no-shows, noncompliance or failure to follow clinician instructions about an important health issue, abusive behavior toward staff, and/or failure to pay your bill.

If you are dismissed we will send you a written notification via certified mail to your last known address. We will provide emergency services for a period of 30 days beyond the date of the letter. We will send a copy of your medical records to your new provider at your request following our record release protocol.

Client(s) Signature(s): _____ Date:_____
(If 12 years old or older)

Parent(s) Signature(s): _____ Date:_____

Staff(s) Signature(s): _____ Date:_____

Go Paperless! By providing your email address, you authorize Lindsay Fleming, LPC, LLC to issue your invoices and statements via email. You may withdraw your consent at any time by providing a request in writing.

_____@_____ _____
Email address (PLEASE PRINT CLEARLY!) Signature

Emergencies: In a crisis situation, call 911 or go immediately to your local emergency room.