MAEDAY CONSULTING SERVICES, LLC

4815 N. Preston HWY # 6
Shepherdsville, KY 40165
502-200-4992

TREATMENT/SERVICE AGREEMENT
Updated 03/08/2017

Please read, initial and keep a copy of this agreement for your reference. It contains important information regarding your private health information (PHI), agreements and notices. Any portion of this agreement that you do not wish to remain in effect must be made in writing and will not be retroactive in nature. Your signature indicates you have received, reviewed, and agreed to all listed policies, practices and billing expectations.

MANDATORY REPORTING AND RELEASE OF INFORMATION_____

Confidentiality applies to all therapeutic services provided. However, specific exclusions of confidentiality include court ordered testimony and information provided with written or verbal consent.

Further, this clinician is obligated by Kentucky state law and by AAMFT to report to the appropriate authorities incidents of abuse or neglect of a child or adult, either new or old, which clinician does not have proof as being previously reported; any threat by client to cause bodily harm to themselves or others (threats to harm others will require at risk person to be notified); any breach of a restraining order, no-contact order or protective order; and failure to follow or cooperate with treatment plans as ordered by the Court, probation, parole or other government agency.

CONTRACT AND CONSENT_____

You, the client (or the legal guardian of the client), do hereby voluntarily consent to participation in mental health therapy. You acknowledge there are not any implied or stated guarantees with services provided. Services will be provided in compliance with the American Association for Marriage and Family Therapy and the Kentucky Board of Licensure for Marriage and Family Therapists' ethical guidelines.

Referrals will be made to another therapist upon request of client or upon the therapist determining clinical needs are beyond the scope of services the therapist is able to provide.

PRIVACY POLICY_____

Your personal health information (PHI) is used for treatment and o arrange payment for services provided. You have rights regarding your PHI. You have the right to specify how I may contact you (email, phone, mail, etc) You have the right to restrict the information I am able to provide others in the process of obtaining payment for services rendered. You have the right to inspect your PHI and are entitled to one (1) free copy. You have the right to request changes to your PHI, if you feel it is incorrect. This request must be made in writing and must specify the reasons you want the record to be changed. You have the right to a full and complete copy of any privacy policies and/or changes made to it. You have the right to file a complaint if you feel your privacy rights have been violated. You may file the complaint with me or with the Kentucky Board of Marriage and Family Therapists. All complaints must be made in writing.

LIMITATIONS OF SCHEDULING AND CRISIS SERVICES_____

Therapist does not provide 24/7 services and communication is limited to regular business hours. Therapist cannot guarantee availability for clients beyond 3 times per month. Regular business hours and hours of availability for appointments are before 5pm. Evening hours are not available and if become necessary for treatment—a referral will be made to another therapist. During a time of crisis you can initially attempt to contact the therapist by TELEPHONE. **DO NOT MAKE CONTACT VIA TEXT MESSAGE REGARDING AN EMERGENCY.** In the event of a crisis and the inability to reach your therapist- Contact the HOPE NOW Hotline at 502-589-4313.

INSURANCE RELEASE AND ASSIGNMENT_____

A release of medical information will be necessary to process insurance claims and to document the eligibility of treatment. Insurance payments will be made directly to the service provider by the insurance agency. At times insurance companies will limit the number of sessions a participant is eligible to receive. Clients are responsible for sessions that are not covered due to a

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lapse in insurance or due to client using maximum allowed sessions. All copays and fees responsible by the client are due at the beginning of each session. Insurance companies may require you to return a Coordination of Benefits form. If you fail to return the document, and it results I the insurance not covering provided services, you will be held responsible for the unpaid balance.

Financial Agreement_____

Initial Assessment $_____ (or current insurance agreement)

Additional Sessions $_____ (or current insurance agreement)

Co-pays and deductibles are due prior to each session. If insurance is being filed, then your contracted rate will be utilized.

Appointments missed or cancelled the same business day will incur a $35 NO SHOW/LATE CANCEL FEE that must be paid before the next scheduled session. This fee is NEVER covered by insurance, HSA, or FSA.

Services are billed at $200 per hour regardless of agreed rate for therapeutic services. **Services** are **not prorated** and are billed in 1 hour increments. Clients are responsible for payment of requested services as they are not covered by insurance. "**Services**" are defined as court reports, court testimony, disability application reports, or any service required/requested outside of therapeutic sessions. Initial service fee of $200 must be paid prior to court testimony and remainder of balance is due within 3 business days.

Client will be responsible for fees for services and appointments not covered by insurance. Fees more than 60 days delinquent are subject to being turned over to a collection agency. All copays and deductible amounts are informed estimates until Explanation of Benefits is received from client's insurance provider and there may be additional fees incurred after EOB has been processed.

Client is responsible to notify clinician of any changes in insurance coverage immediately.

Payments are due at the beginning of each session. Cash, Personal checks, VISA, MASTERCARD, and DISCOVER are accepted. There is a $35 Returned Check or Card Denial charge. Outstanding balances older than 60 days are subject to be sent to collections.

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I, _____ state that I am in agreement and full understanding of above policies related to confidentiality, insurance releases, consent for treatment, mandatory reporting, privacy practices, financial agreements and agree to abide by expectations as described above.

_____
Name and relation to client

_____
Enrica Thomas
Licensed Marriage and Family Therapist

_____
Date

_____
Date

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