

CLIENT SERVICE AGREEMENT

I welcome you as a client. Clarity regarding our relationship is essential for a helpful and successful outcome in your therapy. Please read the following agreement. Feel free to discuss any part of it with me. I encourage you to please let me know if you ever have any questions or concerns regarding my policies or your treatment.

APPOINTMENTS AND CANCELLATIONS: Sessions are scheduled for 45 minutes, allowing for notes, case review, and phone calls. A scheduled appointment commits the time to you and, unless 24 hours (1 day) advance notice is given, you will be charged for a missed appointment or late cancellation. (Insurance companies do not reimburse for missed sessions)

PHONE CALLS AND EMERGENCIES: Jill Dodge, LCSW is available by phone for brief telephone consultations between sessions without charge. Longer phone conversations will be charged on a prorated basis at the same rate as an individual session. Most insurance companies will not pay for telephone sessions. Jill Dodge, LCSW will be glad to schedule to meet with you before your next regular session if needed. You may leave a confidential message on Jill's voice mail at any time. The number to reach her is: 619/ 615-5065. She returns calls Monday-Thursday between the hours of 9am and 7pm. Messages left after hours or on the weekends or holidays will not be returned until the next business day. If you can not wait for a call back or if you are having a mental health crisis after hours please call the San Diego Crisis line at 800/479-3339. **If you are experiencing a life threatening emergency please call 911 or go to the nearest emergency room.**

THERAPIST COMMUNICATION: Jill Dodge LCSW may need to contact you by telephone, mail or other means. Please indicate whether she may contact you at: Home: _____ Work: _____ Cell: _____.

Please also let her know if you do not wish to be contacted at a particular time or place, or by a particular means.

CONSENT FOR TREATMENT: I authorize and direct Jill Dodge LCSW, license #5760 to perform such therapeutic procedures that in her professional judgment are advisable for the well being of myself, my child and/or family. I understand that the purpose of these procedures will be explained to me upon my request and subject to my verbal agreement. I also understand that while therapy is designed to be helpful, it may at times be difficult and uncomfortable. I understand that no warranty or guarantee is made as to the results of this treatment. Maximum benefit will occur with consistent attendance and open communication between me and Jill.

TERMINATION: Length of treatment is individually determined and mutually decided upon. So, if for any reason you wish to discontinue therapy, please discuss this with Jill.

CONFIDENTIALITY: All information disclosed within sessions (including that of minors) is confidential and will only be released with your written permission except where disclosure is required by law. Disclosure is required in the following circumstances: where there is a reasonable suspicion of child, elder, or dependent adult abuse; that the client presents a danger of violence to others, or where the client is likely to harm him or herself unless protective measures are taken. Disclosure may also be required pursuant to a legal proceeding.

RELEASE OF INFORMATION: I authorize the release and exchange of information between Jill Dodge LCSW and my referring or personal physician. I also authorize the release of information to any insurer for the purpose of payment, certification, case management, and other purposes related to the benefits of my Health Plan. I agree that if I break the financial agreement, information necessary for collection processing may be released and that I will pay all costs incurred.

PAYMENT FOR SERVICES: I assume responsibility for all charges incurred. Payment is due at the time of each session, unless other arrangements are made.

FEES: The fee for service is \$175.00 for the initial diagnostic session and \$140.00 per session thereafter. Health plan contracted fees apply. Periodically, Jill reviews her fee structure and if a decision is made to change her rates she will let you know well in advance and allow adequate time to discuss this with you. And, if at any time you find that you are unable to continue to pay for therapy, please inform Jill so that she can discuss what options might be available to you.

INSURANCE BILLING AND REIMBURSEMENT: Jill Dodge, LCSW has contracts with certain Insurance Health plans. As a courtesy, insurance claims will be submitted to my carrier at no cost to me. I understand my therapist is not in a position to guarantee my insurance benefits. I understand that I will be financially responsible for all co-payments and/or deductibles. In instances where my insurance does not pay the expected benefits, I understand that I am liable for the full charges.

ASSIGNMENT OF BENEFITS: I hereby assign all medical and/or mental health benefits to which I am entitled, including private or government sponsored insurance, and any other health plans to Jill Dodge LCSW. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

I have read the above, understand the content, agree to the terms and conditions, and acknowledge receipt of a copy of this form.

Client name (printed)

Responsible party (signature)

Date

Jill K. Dodge, LCSW

Date