

Hope Counseling Inc., 130 S Indian River Dr. Suite 301
Ft Pierce, FL 34950

CLIENT(S)//THERAPIST AGREEMENT between HOPE COUNSELING, INC. and

(Client) _____

CONFIDENTIALITY: Hope Counseling Inc. will legally abide by the laws and Certifying Board regulations concerning client(s) to confidentiality. Information released from Hope Counseling Inc. will be by informed consent signed by the client(s) before providing information to other persons or agencies. Legal exceptions to this rule only apply in cases of child abuse, threats of self-demise or violence, danger to self or others, or subpoena and court order.

EMERGENCY: As we are not staffed 24 hours a day, in the event of an after hours crisis, we encourage you to visit the emergency room of the nearest hospital where you will receive prompt attention, especially in cases involving medication. Please also leave a message at our office and page number.

PAYMENT: Payment is due at the end of each session.

- A) Fees are based on 50 minute sessions at our usual and customary fee of \$140.00 per session, or at a sliding fee scale of \$10 per \$10,000 Annual Gross Family Income, with a \$40.00 minimum per session.
- B) Extra fees exist for longer evaluations, testing, expert witness fees, consultation, and test interpretation.
- C) All reports are billed at a minimum \$100.00 based on \$200.00 per hour.
- D) Telephone calls are billed at \$2.00 a minute in blocks of 5 minutes.
- E) Gross Family Income: _____ Agreed Counseling Fee: _____

(Based on sliding fee scale or agreement with therapist)

CANCELLATION/REFUND: Cancellations must be made at least 24 hours prior to the time of the scheduled appointment or the full amount will be charged to your account, except in the cases of obvious emergencies. Excessive cancellations will result in termination of treatment.

COUNSELOR NOTIFICATION: The client(s) has received information from Hope Counseling Inc. which provides data on the counselor's credentials and the client(s) has been notified of counselor's qualifications and licensure.

CONSENT TO TREAT: The client(s) has been made aware and consents to the nature, structure and limitations of the treatment, and understands the limitations or exceptions to confidentiality within the family or marriage when in family or marital counseling. Unless noted otherwise, the client(s) understand and freely accepts that Hope Counseling Inc. offers clinical Christian counseling from a Biblical foundation.

I fully understand and agree to the Client(s)//Therapist Agreement with Hope Counseling Inc.

Date: _____ Client(s): _____ / _____

Date: _____ Guardian (s): _____ / _____

Date: _____ Therapist: _____ / _____

(To be signed by counseling clients before beginning treatment)