The Health and Wellness Source, LLC * Sharon G. Richardson, LCSW-C *Psychotherapeutic Services*

4230 Forbes Blvd., Suite A, Lanham, MD 20706

CONSENT FOR TREATMENT & FINANCIAL AGREEMENT

SIGNATURE ON FILE FORM FOR THE RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS *(rev.9/1/2014)*

Confidentiality

1. All patient information is confidential and cannot be released to a third party except with specific authorization by the patient (If needed, please request a Release of Information form). However, there do exist a few limits to this confidentiality:
   a. *If child or elder abuse is revealed in the context of the therapeutic relationship, this must be reported to the proper authorities, and confidentiality may be broken.*
   b. *If the patient poses a serious danger to himself/herself or others, confidentiality may be broken in an attempt to provide medical/mental health treatment and/or safety.*
   c. *The therapist is obligated to warn a person if he/she thinks this person is likely to become a victim of violence at the hands of a client.*

Treatment

1. Should you choose to make a commitment to psychotherapy, we will discuss your treatment plan. Please feel free to ask questions or voice any concerns at any time during the duration of treatment. We should both have a clear understanding of your treatment goals, and both commit to active participation toward these goals.
2. At any time, either of us may re-evaluate our therapeutic relationship. Please feel free to raise any concerns or questions at any time. If it becomes clear the therapeutic relationship has become ineffective or non-therapeutic, I may suggest that you seek alternative care, and I will provide you with appropriate referrals.

Duty to Warn

1. In the event that I reasonably believe that you are a danger-physically or emotionally-to yourself or to another person, I will warn the person in danger and contact the following person, in addition to medical and law enforcement personnel. By signing this consent form, you give your consent to make this contact, in these circumstances.
   Name: _____Relationship: _____Tel.#:_____

Fee Schedule *(all fees, including co-payments. must be paid in advance of services being rendered)*

1. **Initial Consultation/Session (45-50 minutes): $175**
2. **Follow-up sessions-*individual* (45 minutes): $160**
3. **Follow-up sessions-*family or couple/marital* (45 minutes): $175**
4. **Treatment/Progress Letter (1-2 page)- $200 *(add $50 expedited fee if requested less than 7 business days before needed)***
5. **Court appearance/testimony: $200 per clock hour *(min. 3 hours)*-including travel and waiting time**
   (Any additional time beyond this time frame would be assessed at the rate of $200 per clock hour (i.e., if I am detained at court, outside of the 3-hour time frame-either before or after hearing time-then there will be additional fees). The total for the estimated time allotted, at this point, is $600. I would need to be retained, in full, for the estimated time allotted, no less than 7 business days prior to the hearing date, so I may solidify any necessary accommodations to my calendar for the court hearing date. I will in turn provide you with a detailed receipt of advance payment. Any additional fees beyond the estimated allotment will be invoiced and payable at a later date, no later than 30 days post-hearing date.
   For your convenience, you are more than welcome to mail the retainer to my office, addressed to my attention: 4230 Forbes Blvd., Suite A, Lanham, MD 20706, or make payment through my website at: www.thehealthandwellnesssource.com).
6. **Missed session/late cancellation fee: full rate as indicated above**
7. **I do not bill for routine telephone calls or emails, such as making/cancelling appointments. For more involved calls, emails/concerns, that extend beyond 10 minutes-whether scheduled or unscheduled-I will charge a prorated rate based on my general rate, to credit card on file.**

Billing

1. Full Payment and/or any co-payment(s) is/are due in full at the time services are rendered/prior to start of session. Follow this checklist to help ensure a smooth billing process: **BEFORE YOUR APPOINTMENT, you should: 1)** Contact your insurance company to make sure you understand your benefits and your plan's requirements; 2) Confirm that Sharon G. Richardson, LCSW-C, is a contracted provider of services for your plan; 3) Obtain a referral, if required by your insurance company; and 4) Know the limitations of the referral and obtain an extension or expansion of the scope of the referral if needed.
2. The preferred form of payment is in the form of personal checks, cash or debit card**. *There is a 5% fee for debit card transactions.***
3. If a personal check is returned for insufficient funds, there will be a **$50** charge, and full payment will be expected immediately. The credit card on file will be charged. If a second check is returned for insufficient funds, I will no longer be able to accept personal checks, and full payment will be expected in the form of cash or debit card.
4. **If your insurance company does not make full reimbursement, the balance due will be charged to credit card on file. If you do not leave your credit card information on file, you will be invoiced the total amount due and assessed a late fee of 5% for any unpaid balance, until full payment has been made.**
5. Please be aware that insurance companies require that a diagnosis be submitted with each bill in order to receive reimbursement. If you have concerns about this, please feel free to discuss them with me. If you have any other questions about insurance reimbursement, please contact your specific plan.

(AND, If client under 18), **PARENT/GUARDIAN MUST SIGN**

CLIENT *(Person being seen)* Printed Name: _____ INITIAL: _____ Date: _____

********PLEASE REVIEW AND COMPLETE REVERSE SIDE>>>>>>>>>>>>>>>>>********

Appointments, Cancellation, and Late Arrival Policy

1. Please provide 36 ***hours (or at least 1 – ½ business days')*** notice if you need to cancel or change an appointment. If you provide this, you will not be charged. If you provide less than 36 hours (1 – ½ business days') notice to cancel or change an appointment, you will be charged the *full appt. rate (whether emergency or non-emergency), which must be paid prior to scheduling of next session; your ins. company will not be billed for missed sessions.* ***MISSED EAP SESSIONS WILL BE FORFEITED.***
2. Appointments canceled on a Saturday or Sunday for the following Monday, do NOT count as 1- ½ business days, and will be charged the full session rate. In the event that two scheduled appointments are canceled or missed in a row, we will discuss the therapeutic relationship to determine its ongoing effectiveness.
3. If I cancel an appointment, you will not be charged for that cancelled appointment.
4. Each client's (45-minute) session is reserved specifically for them. For this reason, visits will begin and end on time, and I am unable to extend a session beyond the agreed upon time. Thus, if a client arrives late for his/her scheduled appointment, that time is lost from the session. If I am late, I will make sure that you get your full appointment time- *either that same day, or on a mutually agreed-upon date and time*.
5. Appts. are scheduled on a first-come, first-serve basis. Standing appointments may be reserved for regular, long-term clients.

Contact Information

1. **My office/cell phone number is 240-350-9777. My email is: sghrichard@aol.com.** ***Text message and email are the PREFERRED methods of communication for scheduling/rescheduling, and cancellations,*** *as I am unable to answer the phone when I am in sessions. Any voice-mail messages left may not be checked until the next business day. I typically check text messages and emails between sessions, which come through directly on my cell phone.*
2. Should you call and choose to leave a voice-mail message, I will get back to you within 24 hours or the next business day. When you leave a message please leave your full name, the time and day you called, a call-back number, and whether I am permitted to leave a detailed message at that number. If you have not heard back from me within the above prescribed time frame, please feel free to call back, as the message quality may have been unclear.
3. In the event of a psychiatric/medical emergency, please call 911.

Consent to Treatment *(to be completed by CLIENT or PARENT/GUARDIAN, if client is under 18):*

I, _____,voluntarily agree to receive mental health assessment, care, treatment, or services, and authorize **Sharon G. Richardson, LCSW-C,** to provide such care, treatment, or services as are considered necessary and advisable. I understand and agree that I will participate in the planning of my care, treatment, or services, and that I may stop such care, treatment, or services that I receive through the undersigned therapist at any time. By signing this consent form, I, the undersigned client, acknowledge that I have both read and understood all the terms and information contained herein.

Financial Agreement

I, _____,authorize **Sharon G. Richardson, LCSW-C**, to release psychological/medical information pertaining to my examination, history, and medical expenses to my insurance company(ies)* for the purpose of processing insurance claims. This release may include reviewing and/or photocopying pertinent documents for the purposes of payment by my insurance company(ies). I understand that the undersigned is fully responsible for the bill, despite any previous financial agreement made including, but not limited to, custodial and divorce decrees. I authorize **Sharon G. Richardson, LCSW-C** and employees and agents to release information pertinent to billing and collecting any outstanding balances on my account. I authorize payment of medical insurance benefits to be made directly to **Sharon G. Richardson, LCSW-C.** I permit a copy of this authorization to be used in place of the original. I understand that my insurance policy may have certain limitations on mental health benefits in the form of precertification, closed provider networks, number of visits allowed or dollar amount per policy year as well as lifetime maximum benefits. **I agree to accept full responsibility for charges once these limitations have been reached.** I understand that in the event my delinquent account is referred to an attorney for collection, I agree to accept full financial responsibility for payment of all reasonable attorney fees and costs incurred by **Sharon G. Richardson, LCSW-C**, in the collection of said account.

PARENT/GUARDIAN Printed Name *(if Client under 18)***:** _____

_____	_____	_____
CLIENT *(Person being seen)* **Printed Name**	**CLIENT Signature** *(or Parent/Guardian, if Client under 18)*	**Date**

_____	_____	**Sharon G. Richardson, LCSW-C**
SIGNATURE OF THWS STAFF COMPLETING INTAKE	**DATE**	**MD License #: 11195**

THANK YOU*. (Please feel free to request a copy of this signed agreement, for your records.)*