

**Amy Cohen, MSW, LISW-S**  
**Licensed Independent Social Worker**

## **PSYCHOTHERAPIST-CLIENT SERVICES AGREEMENT**

### **WELCOME**

Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully and keep this copy for your records. We can discuss any questions that you have at your first appointment.

### **PSYCHOTHERAPY SERVICES**

Our first session or two will involve an assessment of your needs. By the end of this time, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy can involve a large commitment of time, energy and money, so you should be very careful about the therapist you select. If you have any questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion. After the initial assessment sessions, I will schedule 50 minute sessions at a time and frequency we agree upon based on your treatment needs.

### **PROFESSIONAL FEES**

My self-pay fee for the initial session is \$120 and \$100 per subsequent 50 minute sessions and pro-rated accordingly. In addition to appointments, I charge this amount for other professional services you may need. These services include, but are not limited to report writing, telephone conversations lasting longer than 10 minutes, consulting with other professionals with your permission, preparation of records and treatment summaries, and the time spent performing any other service you may request of me. A \$30 fee will be charged for returned checks.

Your session is reserved exclusively for you. If you do not show up for your appointment, you will be required to pay the full cost of the session. If you do not provide 24 hours advance notice of cancellation of your appointment, you will be charged \$50. These charges cannot be billed to insurance.

Being a witness or expert legal proceedings can have many risks to the therapeutic relationship. It is my policy to avoid being involved in legal proceedings if at all possible to protect the integrity and confidentiality of the therapist/client relationship and to avoid dual roles. If you become involved in a divorce or custody dispute, I will not provide evaluation or expert testimony regarding child custody issues in court. You will need to hire an independent mental health professional for any evaluation or testimony you require. If you become involved in legal proceedings that require my participation, you will be responsible for the cost of my professional time, including preparation and transportation costs, even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge \$200 per hour for preparation and attendance at any legal proceeding including travel time door-door.

If you are requesting copies of records for yourself or to be sent to other professionals, you will be billed a copying fee of \$1 per page for the first ten pages, 50 cents per page for pages in excess of eleven, plus a \$15 fee for records research, plus postage.

### **BILLING/PAYMENTS AND INSURANCE REIMBURSEMENT**

Fee payment is expected at the beginning of each session. I accept cash, check, and credit cards for payment of services. If I am a contracted provider on your insurance plan or your policy includes out-of-network benefits, I will fill out forms and provide assistance in helping you to receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of my fees. If you have a co-pay or need to meet a

deductible, it is required that you pay this at each session. It is very important that you find out exactly what mental health services your insurance policy covers.

Please feel free to contact Amy VanHorn at any time regarding your account. She can be reached at 513-489-8600.

**CONTACTING ME**

Due to my work schedule, I am often not immediately available by phone. When I am unavailable, you may leave a message on my confidential voicemail, which I monitor frequently. I will make every effort to return your call the same day. Otherwise, you can expect a call on the next business day at the latest. If you are difficult to reach, please inform me of the times when you will be available. If you are unable to reach me and feel that you cannot wait for me to return your call, contact your family physician, the nearest emergency room, or call 911.

**CONFIDENTIALITY**

Within the limitations discussed below, the information that you reveal to me during our professional relationship will be kept confidential and will not be released to anyone without your written consent. However, certain conditions do require, in keeping with my professional Code of Ethics and the mental health laws of Ohio, that confidentiality and privileged communication be breached, including:

1. If you present a danger to yourself
2. If you present an imminent danger to another person
3. If there is reason to believe that child abuse or neglect is present
4. If a legitimate court order is issued
5. If the treatment is ordered under the supervision of the court
6. If an insurance company requires you to consent to release of records and/or information to them as a condition of reimbursement.

I will obtain from you a separate release of information authorization when you wish to request or allow me to communicate with others about therapy issues. When this information is released, however, I cannot control how the information is treated. Your signature is your agreement that you understand that I will not be responsible for any injury or claim for damages arising from the release of records or information that has been conveyed to others, whether without your permission (when the release of information is required by law) or with your permission, including but not limited to doctors, mental health professionals, teachers, or insurance companies.

**CONSENT TO TREATMENT**

By signing this Psychotherapist-Client Services Agreement, I acknowledge that I have read, understand, and agree to the terms and conditions contained in this form. I have been given appropriate opportunity to address any questions or request clarification for anything that is unclear to me. I am voluntarily agreeing to receive mental health assessment, treatment and services, and I understand that I may stop such treatment or services at any time.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

**I hereby authorize the release of necessary medical information for insurance reimbursement purposes and the payment of medical benefits to the provider of services.**

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date