Compassionate Souls Counseling
101 Timberlachen Circle Suite 101
Lake Mary FL 32746-6124
3212623442

4. Client Rights and Responsibilities

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time.Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your responsibility.

INDIVIDUAL'S FINANCIAL RESPONSIBILITY

1) The standard fee is $125.00 per session. If you are experiencing financial hardship you may request some reduction in your fee, which your therapist may grant on a limited or temporary basis, and is subject to your therapist's discretion and availability of services

2) You may pay by cash or check. Please be advised that you are required to provide and maintain on file a valid credit card number and authorization. This information will be maintained in strict confidentiality. Credit card and debit card payments are accepted for your convenience. Transaction fees will be added on to each credit card payment

3) Payment for services is to be made to Compassionate Souls Counseling at the time services are delivered. Any checks returned for insufficient funds are subject to a $ 35.00 fee each time they are submitted. This fee is due prior to obtaining additional services.

4) I understand that Compassionate Souls Counseling will provide courtesy billing to my insurance but that I am financially responsible for my (if any) health insurance deductible,coinsurance or non-covered service.

5) Co-payments and out-of-pocket costs are due at time of service. In the event that my health plan determines a service to be "not payable", "Uninsured" or ANY other denied reason, I will be responsible for COMPLETE session charge and agree to pay the costs of all services provided.

I have read, understand and agree to the Individual's Financial Responsibility

1-E-Sign: _____

1-Name/Relationship: _____

CANCELLATION AND NO SHOW POLICY

Your appointment times are very important to Alison Garcia and more importantly to continuity of your care.

1) If you need to cancel or reschedule an appointment, please give us 48 business hours advance notice, otherwise you will be charged the ENTIRE fee for the session. The same policy applies if you fail to show up for your session.

2) Please be advised that your insurance will not cover late cancellations or no-shows. If you have a "No Show" or Late Cancellation your credit card on file will be automatically charged for such fees. Repeat cancellations or failure to pay your fees will result in termination of services. The Cancellation and No Show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

We sincerely appreciate your cooperation regarding financial matters.

I have read, understand and agree to this Cancellation and No Show Policy

2-E-Sign: _____

2-Name/Relationship: _____

CLIENT RIGHTS

1) To receive competent professional services

2) To obtain information about the services provided to you.

3) Right to request how we contact you. It is our normal practice to communicate with you at your home address and daytime phone number you provided. We may leave messages on your voicemail. You have the right to request that our office communicate with you in a particular way.

4) Right to have input in the design and implementation of an individualized treatment plan.

5) Right to request restrictions on uses and disclosures of your health information. You have the right to ask for restrictions on certain uses and disclosures of your health information. This request must be in writing. However, we are not required to agree to such a request.

6) Right to terminate therapeutic services. I invite you to discuss any concerns you may have regarding the services provided to you so that an effort can be made to meet your specific needs.

7) Right to request a referral to adjunct services in the community for your benefit.

CLIENT RESPONSIBILITIES:

1) Clients are expected to pay the fee for each session of 45 minutes in length at the time that services are rendered. Telephone conversations will be limited to cancellations and re-scheduling only. Clinical issues need to be discussed during sessions. Off-site visits, report writing and reading, consultation with other professionals, release of information, reading records, longer sessions, travel time, etc. will be charged on an hourly rate of $125.00 per hour

2) To keep your appointments or give 48 hours (business hours) cancellation notice. You will be charged the full fee for the session for late cancellations or no-shows

3) To express yourself respectfully, and to engage in appropriate behavior during sessions

4) To provide and maintain accurate information on all forms and requests for information.

5) To follow recommendations made by your therapist, and attend regular visits to ensure continuity of care in your treatment

6) To refrain from violent or threatening behavior or language

7) To accept and follow through with referral services recommended for you and/or your minor child

3-E-Sign: _____

3-Name/Relationship: _____

Today's Date: _____