SAMARITAN COUNSELING CENTER AGREEMENT

Print Name of Client: _____

Consent for Treatment: I consent to participate in therapy with the therapist who signs this agreement with me. I understand that I need to actively participate in the process and be honest about my feelings and actions. I understand I may experience uncomfortable feelings as part of this process. I have discussed the goals, objectives, and methods of my treatment plan with my therapist. I understand this plan may be modified over time. I understand I may discuss the benefits, risks, alternatives and nature of the treatment to be employed with my therapist when requested. Samaritan Counseling Center is an interfaith organization and we value including a client's beliefs and practices as part of the therapeutic process. It is our philosophy to work with the belief system of the client. The Center's therapists do not impose their personal beliefs upon clients; they include discussion of spirituality according to the expressed preference of the client.

Confidentiality: I acknowledge Samaritan Counseling Center complies with HIPAA and Indiana State laws regarding confidentiality. I have read the summary of my rights and received the full statement of privacy policies and rights in keeping with HIPAA requirements. I am also aware that Samaritan policy specifies that my counselor may, on occasion, consult with other therapists on staff to ensure the appropriate treatment is provided.

Grievances: If I have a complaint about my service, I will discuss it with my therapist. If that does not resolve the problem, I may contact the Executive Director to further discuss the issue.

Fees for Service: My fee will be discussed and set with my therapist during the first session. The options are listed below and mine is selected.

_____I agree to pay the full fee of $150 for the first session and $130.00 for subsequent sessions.

_____I will be using insurance that Samaritan has contracted with to provide services (i.e., PPO or managed care). I agree to pay the deductible and/or co-payment as indicated by my insurance company. I understand I am financially responsible for all treatment the insurance company does not pay for.

_____I will be using Medicare benefits to pay for my counseling. I understand that not all Samaritan counselors are able to accept Medicare reimbursement and I have discussed this with my counselor. I understand I am financially responsible for all treatment that Medicare or other insurance does not pay for.

_____I require a fee subsidy. Fee subsidies will be discussed with you by your therapist. This can be paid over time and no interest or penalties will be charged. I understand the Center reviews such fees two times per year. I also understand that this fee will be reviewed if my financial situation changes. Please fill out the Samaritan Counseling Center's, Inc. Fee Subsidy Application Form and honestly discuss your financial situation with your counselor.

I agree to pay $ _____per session. I require a payment plan to make ____Weekly ____Monthly payments.

I certify with my signature below that I have read, understand, and agree with the contents of this therapy agreement.

_____ _____

Client **Date**

_____

Parent/Legal Guardian

_____

Therapist

For Counselor Use:

Silent Samaritan

_____yes _____no

Revised 9/27/12