CONNECTIONS
Family Counseling

CONTRACT FOR THERAPEUTIC SERVICES

I. The Therapy Process.

Connections Family Counseling, LLC/I provide therapy services from a trauma informed integration of family systems and attachment theory perspectives to understand and effect change in families and individuals. I incorporate a variety of theoretical approaches to best meet your needs. Participating in therapy can result in a number of benefits, including spiritual growth, a better understanding of personal goals and values, improved interpersonal relationships, and resolution of specific concerns that led you to seek therapy. Working towards these benefits, however, requires effort on your part and may result in your experiencing considerable discomfort. Change will sometimes be easy and swift, but it can be slow and frustrating.

By the end of the fourth session of therapy, together, we will set the goals of therapy. As the client, it is important that you agree with the goals. I will endeavor to assist you in setting goals that are achievable and beneficial to you in the fewest sessions possible. I will also work to the keep the goals of therapy in sight. It may become necessary to alter the goals of therapy based on circumstances. However, any changes in the goals will be upon mutual agreement.

II. Office Policies.

Payment for services: You are expected to pay for services at the time they are rendered unless other arrangements have been made. Please notify me if any problem arises regarding your ability to make timely payment. Payments can be made via cash, check, or credit card. For any returned checks, a fee of $30.00 will be assessed.

Insurance reimbursement: I am on the following insurance panels:

Blue Cross/Blue Shield of Illinois

I will submit insurance claims only for the above insurance providers. Patients covered under another provider will bill their own insurance company. I do not bill other insurance companies, nor do I accept payments from them. All co-payments are due at the time services are provided.

Cancellation: Since appointments reserve time specifically for you, a minimum of 24 hours notice is required for rescheduling or cancellation of an appointment. A fee of $50 will be charged for sessions missed without such notification. I reserve the right to terminate services with you if you fail to attend a scheduled session without adequate (24 hours) notice.

Telephone time: After five minutes of telephone time, you will be charged at your regular fee, calculated at six-minute increments.

Sessions greater than 50 minutes: Sessions that go beyond 50 minutes will be prorated to the nearest quarter hour, unless you have made prior arrangements with me.

Notice Regarding Additional Fees Not Covered by Insurance:

1. Missed appointments and Late cancellations (without 24 hours of advance notice): $50 for holding an appointment slot. This is not a fee that your insurance company will cover.

2. Written Reports/Letters/Forms: Pro-rated at my hourly rate. Fees are discussed in session.

3. After Hour Phone Calls (Non-Emergency) or consultative phone calls with other professionals: Pro-rated at my hourly rate. Fees are discussed in session.

4. Any meetings, tele-conferences or Court hearings that I am requested to attend will be charged at my pro-rated hourly rate. Fees are discussed in session.

III. Professional Boundaries.

Chance meetings: If by happenstance we should encounter each other outside the office, I will not initiate verbal communication (which includes discussing your personal information). This is to maintain a therapeutic boundary as well as maintain your confidentiality.

IV. Fees and Appointments.

I agree to enter therapy with Connections Family Counseling, LLC & Mark L. Vander Ley, MC, LCPC. I agree to pay the fee of $125.00 for each completed 45-50 minute session (pro rata for longer sessions). I will make payment in cash, check, or credit card at the time of the therapy appointment, unless we have made other arrangements in advance. I understand that I can leave therapy at any time. I am contracting to only pay for therapy services provided, sessions I miss without providing 24 hours notice, and telephone time as outlined in Part II of this contract.

Client's Signature_____ Date_____

Client's Signature_____ Date_____

Parent/Guardian_____ Date_____

Parent/Guardian_____ Date_____

Therapist's Signature_____ Date_____

V. Client Rights/Consent to Treatment.

1. You have the right to ask questions about any procedures used during therapy; if you desire, I will explain my approach and methods to you. If I see a child under the age of 18, custodial parents/guardians have a right to information shared in the session, though exercising this right may be detrimental to the therapeutic process, and so you may decide to allow confidentiality between
the child and the Therapist.

2. You have the right to decide not to receive therapeutic assistance from me; if you desire, I will provide you with the names of other qualified professionals whose services you might prefer.

3. You have the right to end therapy at any time without any moral, legal, or financial obligations other than those already accrued. I ask that you contact me by phone or in writing if you make such a decision without consulting me.

4. You have a right to review your records in the files. Please refer to the Confidentiality and Privacy Policy form (HIPAA) for specific details.

5. One of the most important rights involves confidentiality: within limits of the HIPAA law, information revealed by you during therapy will be kept strictly confidential and will not be revealed to any other person or agency without your written permission. Additionally, when more than one family member or a couple is being seen in therapy, the Therapist views the family/couple as the client. Therefore, releases of information for family/couples' sessions require the written approval of every consenting member of the family/couple who was present at any time during the treatment.

6. If you request it, any part of your record in my file can be released to any person or agency you designate. I will tell you at the time whether or not I think releasing the information in question to that person or agency might be harmful to you in any way.

7. You should also know that there are certain situations in which I am required by law to reveal information obtained during therapy to other persons or agencies without your permission. Also, I am not required to inform you of my actions in this regard. These situations are as follows: a) if you threaten grave or bodily harm or death to another person, I am required by law to disclose this information to the appropriate authority; b) If a court of law issues a legitimate Court Order (signed by a Judge), I am required by law to provide the information specifically described in that order; c) If you reveal information relative to child abuse, child neglect, or elder abuse, I am required by law to report this to the appropriate authority; d) If you are in therapy by order of a Court of law, the results of the treatment ordered must be revealed to the Court; and e) If you are seeking payment through an insurance company, I will be required to reveal confidential information to them (each insurer is different).

8. You have the right to know about the possible harmful results of therapy. This may include problems arising from insistence on using medical insurance for psychotherapy. Harmful events could include (but are not limited to): denial of insurability when applying for medical and disability insurance due to DSM-V diagnosis (mental illness diagnosis, which are usually required for reimbursements under medical insurance); company (mis) control of information when claims are processed; loss of confidentially due to the large number of persons handling claims; loss of employment, and repercussions of diagnosis in situations which require truthfulness about "mental illness," including driver's licenses applications, concealed weapon permits, and job applications.

9. Therapy will seek to meet goals established by all persons involved, usually revolving around a specific presenting problem. A major benefit that may be gained from participating in therapy includes a better ability to handle or cope with

marital, family, and other interpersonal relationships. Another possible benefit may be a greater understanding of family, marital and personal goals and values; that may lead to a greater maturity and happiness as individual and increased relational harmony. Other benefits relate to the probable outcomes resulting from specific concerns brought to therapy. In working towards these potential benefits however, therapy will require that consistent efforts be made to change and may involve the experiencing of significant discomfort. Therapeutically resolving unpleasant events and relationship patterns can arouse intense feelings. Seeking to resolve problems can similarly lead to discomfort as well as relationship changes that may not be originally intended.

10. Please note that the quickest way to get ahold of me is by voicemail. Voice messages will be returned quickly.

11. You are required to keep me informed of any changes to your insurance. Having insurance does not necessitate payment and you will be financially responsible for any balances that your insurance does not cover.

I/We authorize and request Connections Family Counseling, LLC & Mark L. Vander Ley MC, LCPC to carry out therapeutic services as outlined in the above information. I have read and fully understand the consent for treatment.

Client's Signature_____ Date_____

Client's Signature_____ Date_____

Client's Signature_____ Date_____

Client's Signature_____ Date_____

Therapist's Signature_____Date_____

VI. **Parents**

1. When working with an individual child, I respect his or her right to confidentiality. I will consult with you about your child's progress. Both parents are entitled to know the nature and progress of your child's therapeutic services.

2. If I am seeing your child in individual sessions, I appreciate your telling me at the beginning of the session whether there have been any unusual happenings since our last session, or issues of concern prior to your child's session. This exchange must be brief so as not to interfere with the child's therapy session. If a more extended time is needed, please call for a separate appointment or request a telephone session. (See section II concerning telephone calls.)

3. Some children need to know that their parent is present for them in the waiting room. I often involve parents in the session. Please plan to stay in the office while your child is in session. Children should not be left unsupervised in the office at any time. Food is also discouraged in the office.

4. Please encourage your child to use the bathroom prior to the beginning of a session. If your child needs to use the bathroom during the session, you will need to be present to take your child to the restroom.

VII. Consent to Treat Minor.

I, _____ as parent/guardian of _____, a minor child, authorize and request Connections Family Counseling, LLC & Mark L. Vander Ley MC, LCPC to carry out therapeutic services as outlined in the above information. I have read and fully understand the consent for treatment form.

Parent/Guardian Signature_____ Date_____

Parent/Guardian Signature_____ Date_____

Therapist's Signature_____ Date_____