

AGREEMENT FOR PROFESSIONAL SERVICES

Welcome! I am a Licensed Professional Counselor and I appreciate your trust and the opportunity to be of assistance to you. Counseling is holistic and geared to the specific needs of each client. It is comprehensive and collaborative and requires your very active involvement. The therapy approach focuses on the potential for personal growth, problem solving, and decision making. It employs a variety of techniques tailored to your specific needs including coping mechanisms to improve your quality of life. A plan of treatment and/or action is discussed, so you can make the best treatment decisions for you, and /or your minor child. It usually includes some homework items to maximize your therapy dollars. To assure the highest possible outcome for each client, I must point out certain commitments that each client needs to consider before proceeding in a collaborative relationship.

- Client agrees to communicate openly and honestly.
- Client understands that personal growth and learning requires a commitment to change.
- Client agrees to execute action steps discussed in each session and understand that no promises have been made as to the results of treatment or of any procedures provided by this therapist.
- Client realizes there may be times in the process where they may confront realizations that may be uncomfortable to accept.
- Client is aware that they may at any time stop treatment with the therapist and they are only responsible for payment of services that they have already received.
- If, at any time, the client is dissatisfied with the counseling relationship they will fully discuss their views, reasons and plans with the counselor. After regular reviews of progress if the client is not progressing the counselor has an ethical responsibility to suggest that the client see another professional. The Client and therapist will fully discuss their reasoning and recommendations ahead of time so they can come to an agreement.
- If the client is a minor, the guardian understands that while they have the right to general information on issues and progress, some information shared in the professional relationship will be held in confidence by the counselor and the minor child.

Appointments are scheduled by calling during regular office hours. Mon.-Fri. 9:00-5:00. If the therapist doesn't pick up, please leave a voice message on the confidential line and your call will be returned within 24 hrs. excluding weekends and holidays.

Out of Office Contact In a dire emergency, call 911 or go to the nearest emergency room. If you cannot reach me at the cell phone number provided, you can contact your personal physician.

Cancellation Policy I make our meetings a first priority and ask you to do the same. Your session time is reserved for you. A cancelled appointment is an interruption in our work together. If you are unable to keep your appointment, I require 24 hour notice. If you give less than 24 hours notice, you will be charged the regular session rate, unless I am able to fill your time. As a courtesy to clients, I try to provide appointment reminders by text when possible. However, I am not able to guarantee this service. Clients are responsible for recording and keeping scheduled appointments.

Confidentiality for Therapy Services and Consent/ Authorization Agreement The confidentiality of our conversations, including your records, is legally protected by federal and state law, and by my

profession's ethical principles in all but a few rare circumstances. Listed below are two exceptions to confidentiality and for a full disclosure of exceptions refer to <http://www.scstatehouse.gov/code/t40c075.htm> Section 40-75-190. Also, professional ethics prohibits counselors from entering into a sexual relationship with a client. Confidentiality Exceptions: 1. Counselors are mandated reporters for suspected abuse, neglect, or exploitation of a child or vulnerable adult. 2. Counselors have a duty to warn if there is clear and immediate danger to another person or if you are a threat to yourself. This includes persons with HIV/Aids are required by SC law to share their status before intimate sexual contact or sharing needles. **Communication by e-mail is not considered a confidential means of communication. By signing below, I give Myra Gasser consent to leave a telephone message, text, or email reminding me of my next appointment.**

Professional Fee Schedule for counseling/therapy

50 min. initial evaluation \$160.

50 min. sessions = \$135.

Phone Coaching Fees I typically return routine/non-urgent phone calls within the same business day. My policy is to provide quality client care through scheduled office visits, not unscheduled phone calls, so I may direct you to make an appointment. Unscheduled calls in excess of fifteen minutes will be charged a rate consistent with office time.

Skype Appointments Skype appointments can be discussed at the initial evaluation to assess appropriateness for the client. They are scheduled as a regular apt. and are charged accordingly.

Financial Policy I will provide you with a super bill invoice which includes: national provider number and appropriate codes for you to file for reimbursement from your insurance Company. Payment is due at time of service by cash, check, credit card or money order. Any returned checks are subject to a \$30. service fee. Any returned checks must be resolved before future appointments can be arranged.

I acknowledge that I have received and understand the "Agreement for Professional Services" and/or other information about the therapy I am considering, and I have had an opportunity to have all my questions answered. I do hereby seek and consent to take part in the treatment by Myra Gasser a licensed therapist. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to pay this therapist's fee (\$135.00 per 50 min. sessions for regular office visits, \$160.00 for the initial intake session and \$160.00 for 1hour in home sessions). I agree that this financial relationship will continue in effect with the above named professional as long as this counselor provides services or until I inform her, in person, or by telephone.

I agree to cooperate with and abide by all of its provisions as indicated by my signature.

Signature of client (or person acting for client) Date

I, the therapist, have discussed the issues above with the client (and/or parent, or guardian). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

Signature of therapist Date