Counseling and Fee Policy Agreement

Education
M.S.W., Masters of Social Work, New York University, NY
B.A., Human Development and Social Relations, Earlham College, Indiana
Center for the Advancement of Group Studies, New York, NY

Licensure: Licensed Clinical Social Worker, IN, License # 34003810A
Academy of Certified Social Workers, National Certification
Certified Clinical Social Worker, NY, 047868-1

Intake Evaluation
During our first few sessions, we will evaluate the nature of your personal needs and difficulties to determine what type of counseling will be most beneficial for you at this time. A referral may be made for more specialized care, whether in conjunction with our treatment or in lieu of the counseling provided by my office. This evaluation precedes setting the therapeutic covenant between client and counselor.

Indiana state guidelines require that the following information be provided to each client: Sexual contact between client and counselor is not part of the therapeutic process. Sexual intimacy between client and counselor is illegal and should be reported to the Indiana Department of Regulatory Agency's state grievance board. If you have any concerns, please speak to me immediately or soon thereafter. If you have a concern about my professional conduct that has not been properly addressed, than you may contact the state grievance board at the following address: pla5@pla.in.gov.

Fees and Payment
My fee is $100 per session for a clinical hour of 50 minutes. Couples and family sessions meet for 60 minutes with a fee of $125 and groups meet for 90 minutes with a fee of $50 per person. Initial appointments and evaluations are $125. Payment, or copayment, is due in full at the time of each session.

Consultation outside of session that exceeds ten minutes may be billed incrementally at my hourly rate. This includes, but is not limited to, collateral contacts with family members, courts, or schools either in person or via telephone, texting, and/or email correspondence.

Each returned check due to insufficient funds would result in an additional fee of $25. A collection agency may be used for accounts that are 60 days past due. Confidentiality with regards to financial information are waived when submitting insurance claims or to a collection agency.

Scheduling and Cancellations
If you are unable to keep a scheduled appointment, 24 hours notice is required to reschedule. Fees are due in full for any cancellations made with less than 24 hours notice.

Insurance
Clients are responsible for determining their coverage for mental health services with insurance companies. As a provider for certain companies, I will assist you in filing for claims but you are responsible for tracking your deductibles and co-payment requirements for your sessions.

If you choose to file independently with your insurance company, than I will assist you by preparing a monthly statement that you may attach to your claim form. You will need to sign an Insurance Claim Supplement Form authorizing me to provide appropriate information to the insurance company.

Confidentiality
Information that you share during counseling is confidential with some exceptions listed in the Indiana statues. All counselors are legally required to report the threat of homicide or suicide, threat of serious harm to self or others, and/or child abuse, neglect or sexual abuse.

Termination
Although you may decide to end treatment prematurely, I strongly encourage clients to meet for a final session, which allows for discussion, reflection, and closure of the therapeutic process.

Emergencies
I do not provide "emergency services." If you have an urgent concern, I will try to schedule an appointment as soon as possible. If you find that you are in a dire emergency, please dial 911 first and then contact me as soon as you are able.

Referral Release Statement
It is my practice to notify the professional or organization that referred you for counseling following your initial interview. If you do not want me to contact the person or organization that referred you, please indicate this by providing your initials on the line provided _______.

Professional Release Statement
It may be determined that you would benefit from additional services such as a referral to your physician, a psychiatrist, or other professionals for specialized treatment or evaluations. Such referrals would be discussed with you before a contact is made. Your signature below will allow me to release specific clinical information to the professional that may be most useful for your continued treatment.

Consultation, Education and Supervision Release Statement
The undersigned authorizes that some information shared during the counseling sessions may be discussed with other professionals for consultation or educational purposes. Identifying information would remain confidential and information would be handled professionally. The primary focus would be to ensure that you receive the best services possible at all times.

Maintenance of Client Records
Client records will be stored in a locked filing cabinet and will be secured in a locked office or building. All of the above efforts will be made to maintain confidentiality unless discussed otherwise during our session.

Consent to Counseling
I consent to participate in counseling or psychotherapy, which may include evaluation, treatment and/or referrals for additional services. I understand that these services do not come with guarantees, that no guarantees have been given to me, and that there may be risks when participating in these services. I further understand that, at any time I can revoke this consent by putting such request in writing. I agree to pay in full at the time that services are provided. I have read, understood, and agreed to the terms outlined above.

Signature(s):

______________________________________ ______________________________________
Client Date Client Date

____
Parent/Guardian Signature (for minors) Date

____
Debra S. Unger, LCSW, ACSW Date