Total Health Concepts, LLC
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Welcome to Total Health Concepts, LLC
Helping You Renew Balance and Healthy Living

Counseling Agreement

Date: _____
Client Name: _____
Address: _____
City_____State_____Zip_____
Phone: (H) _____(W)_____(C) _____
E-mail: _____
Birth Date: _____ Social Security # _____
Emergency Contact (Name/Phone):_____

When we enter into a relationship with our clients we feel it is important to agree on our mutual rights and responsibilities. Our goal is to provide supportive nutrition, fitness, and/or therapy, which are tailored to your specific needs. On your part, we encourage open communication and a commitment to change through personal and collaborative efforts. The following are our policies and procedures. Please read them carefully and ask us to clarify anything that you do not understand. Please sign a copy of this agreement and a copy of the Informed Consent and Release form (found on our web site). Please bring it with you to your first appointment or fax them to us. We look forward to our work together.

New Client Forms: Forms for "new clients" are located on our website (or can be mailed if needed prior to your appointment) to be completed and brought to first session.

Appointment Scheduling: The client will have a pre-arranged date and time for the sessions (in-person or phone).

Cancellation Procedure: Once the session time is set up, please give at least 48-hour notice if rescheduling. There will be no refund or credit for cancellations made less than 48 hours prior to a scheduled session and you will be responsible for payment of missed sessions.

Payment Procedure: Payment is due at the time of service. Please make checks payable to ***Total Health Concepts, LLC***. Payments can be made by cash, check, or credit card (MC/Visa) for all services.

Insurance Policy: If we are filing insurance for you, you are responsible for any payments that are declined due to any changes in your insurance plan. It is your responsibility to confirm that we are in-network providers before your first appointment. You are responsible for knowing and paying any unmet outstanding deductible by your insurance company. If we are confirmed out-of -network providers, you will be responsible for the regular full fee.

Termination: Our goal is to help clients resolve their presenting problem so that they no longer feel the need for professional assistance. Sometimes this requires only a few sessions. At other times, extended therapy is needed. We see therapy very much as a process where therapist and client work together to set and achieve desired goals. We encourage open dialogue so we can find the treatment approach that best serves you.

Release of Information/Confidentiality: Sessions are protected by confidentiality, which means that information about the Client cannot be given to anyone without express consent (in writing). Our "Authorization Form" must be completed if we need to disclose information to the client's physician, treatment center, or insurance carrier. The Client understands that there are limits to confidentiality:

- To prevent a serious and imminent threat to the health or safety of yourself, another person, or the public
- Child abuse, or neglect or elder abuse is suspected
- If there is an order from the court to subpoena confidential information

The Client understands that communication by E-mail may not be secure and that archives of E-mail communications may be subject to electronic interception or may be kept by third parties (such as ISPs) and be subject to court orders. Please review and sign the information regarding the Notice of Privacy Practices related to the Health Insurance Portability and Accountability Act (HIPPA Form) located on our website.

Emergencies: In case of mental health emergency, call 911, or go to the nearest hospital emergency room, or call your local community mental health center's 24-hour emergency number.

Forms (to be completed and brought to first session):

-Counseling Agreement
-HIPPA Form
-Informed Consent and Release form
-Authorization for Exchange of Information

_____
Client Name (Print)

_____ _____
Signature of Client/Parent/Guardian Date

_____ _____
Signature of Total Health Concepts - Health Team Therapist Date

We are looking forward to our relationship and helping you renew balance and healthy living.

Warmest regards,

Total Health Concepts Professional Team