Phone: (703) 255-7012
Fax: (703) 255-6171
www.totalhealthconcepts.net

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: _____
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.

In the case of inclement weather where the therapist or client are unable to attend session, the following options are available to avoid cancellation fee: 1. Phone session during scheduled time or 2. Reschedule a new time during that week

Payment Procedure: The first session will be scheduled as soon as this agreement is signed and returned to the counselor. 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.

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
- New client Information
- 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