



**Total Health Concepts, LLC**  
115 Beulah Road NE, Suite 200-B  
Vienna, VA 22180

## 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 **24-HOUR** notice directly to your therapist for any appointment you are unable to attend. Call or text your therapist informing of any cancellation or change in your availability. If notice is provided less than 24-hours prior to your scheduled appointment you will be charged for the full fee amount of your session (insurance or private pay rate). This policy also includes **NO-SHOWS** to a scheduled appointment.

To alleviate any cancellation fee being charged to your account, the following options are available:

- Reschedule your appointment time during the same week that your therapist is available, or
- Schedule a phone or Doxy Meeting session during your allotted time you are unable to attend in person

In case of INCLEMENT WEATHER (snow/ice or any other natural disasters) where the therapist or client is unable to attend their scheduled appointment, the following options are available to avoid a cancellation fee:

- Phone or Doxy Meeting session, or
- Reschedule a new appointment time during the same week that your therapist is available

**Session Time:** Allotted session times are based on insurance policy standards of 50 minutes. We strive to maintain these standards, understanding each session is different and more time may be required to manage an emotional concern. However, for consistency purposes and to provide the highest quality of service to all our clients, another therapeutic session should be scheduled to further address the situation. On the 45's (15 minutes to the hour) your therapist will be notifying you of the time left in the session.

**Communication:** We understand texting being an important part of our daily routine as a quick and easy way to communicate with others. However, to ensure confidentiality is maintained, texting between client/therapist is for the sole purpose of scheduling/cancelling and appointment. We do not encourage engaging in therapy via text at any time.

**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 to Disclose Confidential Information

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Client Name (Print)

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Signature of Client/Parent/Guardian

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Date

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Signature of Total Health Concepts - Health Team Therapist

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Date

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

Warmest regards,

Total Health Concepts Professional Team

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