TREATMENT AGREEMENT

1. APPOINTMENTS: When I set an appointment with you, that time is yours and yours alone. The counseling sessions last 50 minutes. I will do my best to be punctual for your appointment unless I have an emergency call. If I am late for the appointment, I will either extend your session (if that works for you and there is no one scheduled after you), or refund 50% your co-pay / counseling fee for that session – whichever you prefer. I ask that you be punctual as well. If you are late, for any reason, you will only receive the remainder of your scheduled time. This is necessary so I can see following clients at their scheduled times. You will, however, be required to pay the full fee.

2. MISSED APPOINTMENTS / LATE CANCELLATIONS: Since scheduling an appointment involves the reservation of time specially set aside for you, a minimum of 48-hour advance notice is required to cancel. You will be charged the full fee I would otherwise get paid by you and / or by your insurance company (in this case, $ _____) for a session missed without such notice. Messages may be left on my voicemail, (615) 481-6196, which will accurately record the date and time you called. Please note that most insurance companies do not reimburse you for missed sessions. At my discretion, a waiver of the fee may be provided for late cancellations caused by certain emergencies. If I cancel the appointment with less than 48 hours notice, you won't have to pay the co-pay / counseling fee for your next appointment.

3. INSURANCE: I accept several insurance plans. In the event that your insurance company does not pay for the services I rendered, or provides incorrect information about your coverage resulting in a denial of the claim, you are responsible for paying me the outstanding amount. If I am not contracted by your insurance plan, we will determine your counseling fee prior to the start of the treatment together.

4. COUNSELING FEES: Counseling fees are set prior to your first appointment. The fee is:
_____ (if no insurance is used)
_____ (co-pay, if insurance is to be billed).
Payment is expected at the time of service unless other contractual arrangements have been made. Fees are to be paid before the beginning of your session.

5. COMMUNICATION
a) Phone calls: they are primarily for scheduling appointments; however, I am available for short consultations not to exceed 10 minutes. For extended calls over 10 minutes, you will be charged according to the prorated hourly fee. In a psychiatric emergency, please call 911, or go to your nearest Hospital Emergency Room and ask for help.
b) Texts: You consent to be contacted via text for the purposes of scheduling and payment. Please note that texts are not a confidential mode of communication.

c) E-mails: Emails requesting information regarding treatment, payment or scheduling will constitute your consent under HIPAA and relevant state laws for me to respond via the same channel in answering your question. Please note that unencrypted e-mail is not considered a confidential mode of communication.

6. RETURNED CHECKS: A penalty fee of $20.00 will be assessed on all checks returned by the bank for any reason. Re-payment of the returned check must be made by cash, cashier's check, or money order only.

7. UNPAID BALANCES: Payment must be made within 30 days of a missed session or a late charge of $20.00 will be assessed. Any accounts with a past due balance of 60 days or more will be handed over to the collection agency, and will incur a $50.00 processing fee. If your account has an unpaid balance at any time, it may be necessary to suspend therapy sessions until the account is paid.

8. CHILDREN: I do not provide care for your children while you are in a counseling session and I am not responsible for any child that is left unsupervised. Young children can be disruptive to other clients, so I ask that you do not bring children to the office unless they are receiving counseling themselves. Should you leave children unattended in the waiting room, I will request that you leave your counseling session to attend to them.

I am dedicated to you and your counseling needs and I appreciate your cooperation in these matters.

By signing this Treatment Agreement, I agree that I am bound by this Agreement, and its terms. I further acknowledge that I am personally responsible for all financial obligations incurred.

The prevailing party in any dispute, claim or controversy arising out of or relating to this Agreement or the breach, termination, enforcement, interpretation or validity thereof shall be entitled to an award of any and all reasonable costs and reasonable attorney's fees incurred in the dispute.

Signature:_____ Date:_____
Client (please print name here: _)

Signature:_____ Date:_____
Edina Kishonthy, M.S., LMFT

For billing purposes, please provide your mailing address, incl. city, state and zip:

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