PROFESSIONAL THERAPY AGREEMENT

1. I understand that each therapy session is 50 minutes long. I understand that the cost of therapy is dependent upon the therapist and is as follows:

   Jen Rives, LMFT - $130 for individual sessions, $150 for couples and family sessions
   Jessi Leader, LAMFT - $110 for individual sessions, $130 for couples and family sessions
   Jessica Sells, MA, LADC - $100 for individual sessions, $120 for couples and family sessions
   Ania Scanlan, MA - $100 for individual sessions, $120 for couples and family sessions

   The first Intake Session is charged at an additional $20. Fees are subject to review and/or change.

2. I understand that services are provided fee for service. Any reimbursement sought through an HSA, FSA, or Out-of-Network benefits is my responsibility. I am responsible to verify that therapy services with Relationship Insights Therapy & Coaching are reimbursable and I will not hold Relationship Insights Therapy & Coaching responsible for any refusals of reimbursements.

3. I agree to pay my session fee before each appointment begins and to pay by cash, check, or credit card. Checks are to made out to *Relationship Insights Therapy & Coaching*. I understand that there is an additional $5 service fee for credit card payments, due at the time of payment.

4. I understand that Relationship Insights Therapy & Coaching aims to create reasonable policies around client no-shows and late-cancels (less than 24 hours notice). Therapeutically, late-cancel fees keep clients accountable to their own self-care commitments, of which therapy is a part. It also keeps a reasonable level of availability for clients to access the therapy that they need. I understand that late-cancels and no-shows take valuable time away from other clients.

   Financially, as a small business, a schedule holds a finite number of revenue-generating appointments per week. I understand that Relationship Insights Therapy & Coaching counts on clients to attend scheduled appointments (with occasional exceptions for emergencies or serious illness). I understand that a no-show or late-cancel means another client cannot be scheduled for that hour.

5. If I do not cancel my appointment at least 24 hours in advance, I understand that I am responsible for a late-cancel or no-show fee of the full session fee (see #1). I agree to allow my credit/debit card to be on file and to be charged the late-cancel fee (plus $5 convenience fee) if I don't pay by check or cash.

   Credit/debit card number on file: _____
   Expiration date (month/year 00/00): _____
   Security Code on Back of Card: _____ Billing Zip Code: _____

6. If I miss 2 or more sessions without 24 hour notice, Relationship Insights Therapy & Coaching reserves the right to terminate our therapy relationship. My therapist will let me know by telephone or email.

7. Should I have any concerns and/or complaints regarding my treatment I can contact the State of Minnesota Regulatory Board of Marriage and Family Therapy at 612-617-2220. I understand that Jessi Leader, is under the supervision of Brier Miller, a Licensed Marriage and Family Therapist; Jessica Sells is under the supervision of Sara Heinzen, a Licensed Marriage and Family Therapist; Ania Scanlan is under the supervision of Jen Rives, a Licensed Marriage and Family Therapist.

8. I understand that my therapist may discuss my case with another therapist or supervisor if needed to provide the best possible treatment. Such discussions will remain private within the consultative relationship and all identifying details will be omitted to protect my privacy.

9. In the event that my therapist reasonably believes that I am in danger to myself or another person, I specifically consent for the undersigned therapist to warn the person in danger and/or contact appropriate medical and law enforcement personnel. I am also aware that all therapists at Relationship Insights Therapy & Coaching, as a mandated reporters, must notify appropriate authorities if they suspect or are told of abuse involving children, elderly or vulnerable adults.

10. Non-secure media transmission and email:

    I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means (See Communications Policy). This authorization will terminate when I ask for termination in writing.

    I authorize Relationship Insights Therapy & Coaching, to transmit to me by non-secure media the following types of protected health information related to my health records and health care treatment:

    1. Information related to the scheduling of meetings or other appointments
    2. Information related to billing and payment
    3. Responses to your emails (if you send them) regarding your thoughts and feelings

    ❑ No ❑ Yes ____ (Please Initial)

11. Permission to Contact by phone: please check yes or no for all of the following and provide your initials.

    CALLING:
    I give my permission to be called at:
    Home: ❑ No ❑ Yes ____ (Please Initial) Cell: ❑ No ❑ Yes ____ (Please Initial)
    Work: ❑ No ❑ Yes ____ (Please Initial)

    VOICEMAIL:
    I give my permission for a message to be left on my voicemail, and understand that my therapist's name will also be left in the voicemail.
    ❑ No ❑ Yes ____ (Please Initial)

    TEXT:
    I give my permission to communicate by text, and understand that my therapist's name may be visible in the texting process.
    ❑ No ❑ Yes ____ (Please Initial)

12. I have read the preceding, and understand the contents of this agreement. I agree to abide by the provisions set forth in this agreement. I have been given a copy of "Client's Rights", "Client Confidentiality, "Notice of Privacy Rights - HIPAA," and "Communications Policy." I have read and understand the information, and agree to the provisions set forth in "Client's Rights", "Client Confidentiality, and "Notice of Privacy Rights - HIPAA," and "Communications Policy." I understand that I am not required to sign this agreement in order to receive treatment. I also understand that I may terminate this authorization at any time.

_____	_____	_____
(*Client Name*)	(*Client Signature*)	(*Date*)
_____	_____	_____
(*Therapist Name*)	(*Therapist Signature*)	(*Date*)