

Family Institute, P.C.

(Independent Practitioners)

503-601-5400

Main Office: 4110 Pacific Ave., Suite 102, Forest Grove, OR 97116
Tigard Office: 9600 SW Oak St [Plaza West], Suite 280, Tigard, OR 97223

Contract, Office Procedure, and Financial Agreement

Please read and *sign two copies*. Keep one for your records

Family Institute, P.C. is a business facility where a number of mental health professionals practice. **Each therapist is an independent practitioner.** The name Family Institute, P.C. is for the purpose of shared office expenses. **Your contract for services is with your therapist only and does not include a contract with any of the other therapists at this site.**

Rights and Risks:

Please feel free to ask questions about any aspect of the counseling process.

If you have been referred by a court or state agency, you have the right to divulge only what you want to be included in a report.

You need to be willing to discuss what troubles you and be open to change.

You may remember unpleasant events, arouse intense emotions, and/or alter close relationships.

Confidentiality:

Information shared will be held in confidence.

Information will not be released without your written consent, except for professional consultation if needed and unless required by law.

I am required by law to disclose information pertaining to suspected child abuse; inability to care for one's basic needs for food, clothing or shelter; and threatened harm to oneself or others.

The courts may in select cases subpoena counseling records.

It is understood that information regarding treatment and diagnosis may be provided to an insurance company.

You may want to discuss further limits or exceptions of confidentiality.

Client Agrees to: *Allow the counselor to be assisted by a co-counselor if the counselor deems it appropriate.*

Note on Privacy: *I understand that the counseling sessions in which I participate with a co-counselor is for the purpose of improving my care. It will not be meant as an invasion of my rights of privacy; therefore, in consideration of the benefits received by me, I specifically waive my rights of privacy for **this purpose only**.*

Appointments:

All office visits are by appointment and may be scheduled through the office manager or your counselor directly.

Please arrive on time, as you use up your own time when you arrive late for an appointment. The usual length of an appointment is 50 minutes.

Late cancellation (less than 24 hours before) *and/or* no-show appointments are billed to the client for the full amount. In the case of illness, please notify us no later than 9:00 a.m. the day of the appointment. Please leave a message if you get the voice mail. If your appointment is cancelled or missed, contact the office for a new appointment time. Insurance companies will not pay for no-show charges or late cancellation charges or for telephone consultations.

Fees:

The client portion (co-pay) of fees is expected at the time of service.

Your health insurance may help you recover some of your counseling costs. Most group policies, but few individual policies cover outpatient psychotherapy. Please verify with your company the amounts of coverage for outpatient psychotherapy by licensed professionals. If your policy requires preauthorization to receive services, this is your responsibility and needs to be handled prior to your first visit.

- Insured client's are expected to take care of their fees as services are rendered. Our office will bill your insurance company for services provided. You will receive a statement each month reflecting any balance due on your account. This office cannot accept responsibility for collecting your insurance claims or for negotiating a settlement on a disputed claim. You are responsible for payment (and insurance claims) on your account. **Failure to pay your part may jeopardize your benefits. Copays are not negotiable.**
- Clients paying on a cash basis, and not billing any insurance company are expected to pay in full at time of service unless a payment plan has been previously arranged.
- Except in the case of minors or when other arrangements are made, the person receiving the counseling service is financially liable.
- Accounts become delinquent after thirty (30) days. **Accounts 90 days in arrears will be terminated.**
- **Phone calls in excess of five (5) minutes will be billed at the usual rate. Insurance does not cover this.**
- Any change in my financial situation I will discuss with my therapist. In the event you find it necessary to change mental health providers and require records to be sent from Family Institute, P.C. your account will need to be paid in full.

I have read, understand and agree to the above policies. I have discussed these policies with my therapist if desired and all questions are answered to my satisfaction. I have been offered a copy of these policies to take with me if I desired.

I hereby authorize Family Institute, P.C. and my therapist to release to my insurance company any information acquired in the course of my therapy (if client is a minor, parent or guardian sign).

I understand my insurance coverage is a relationship between me and my insurance company and I agree to accept financial responsibility for payment of charges incurred. I understand that a re-billing fee/financial charge complying with Oregon State Law will be applied to any overdue balance, and in the event of non-payment, I will bear the cost of collection and/or court costs and reasonable legal fees should this be required.

Consent to Treatment and Fee: I hereby agree to full responsibility for all expenses incurred by or on account of this client and hereby assign Family Institute, P.C. (FI) and all Insurance benefits due to me to the full extent of my financial obligation to FI. I have read and/or received a copy of Family Institute, P.C.'s Privacy Policy. *If conjoint (couple or family) all adults need to sign this contract because of confidentiality and your rights... even though one person is the identified patient (and paying).*

	Bob	Peggy	Wendy	Ed Lindsay	John	Tatiana	Becky
Initial Interview , Assessmt	\$120	\$ 200 (90 min)	\$100	\$ 90	\$ 50	Free (1 st 30 min)	\$ 60
Session Fee (50min)	\$100	\$150	\$ 80	\$ 70	\$ 40	\$70	\$ 60
Client (Copay) Payment	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
Med Management--30 min	NA-\$40	\$90	NA-\$40	NA-\$35	NA-\$20	NA-\$45	NA-\$30
Non or Late Cancellation	\$100	\$150	\$ 80	\$ 70	\$ 40	\$45	\$ 60
Bounced Check Fee	\$ 10	\$ 10	\$ 10	\$ 10	\$ 10	\$ 10	\$ 10

Client(s) Signature(s): _____ **Date:** _____

Therapist Signature: _____ **Date:** _____

Emergencies:

The **best phone number** for all offices is **503-601-5400**. If you receive the voice mail, please leave a message for your personal counselor. Your counselor may be on the phone, in therapy with someone else, or out of the office.

In a crisis situation, if your therapist cannot be reached you may **call the 24-hour Mental Health Crisis Line: (503) 988-4888, or go immediately to your local hospital emergency room.**