Christina R. Perkins, LCSW
4877 Chambliss Ave
Knoxville, TN 37919
P: (865) 924-2558. F: 866-768-6708

Counseling Agreement

Therapy is most effective when the boundaries of the therapeutic relationship are understood and followed by both the therapist and client. These boundaries are professional and ethical guidelines I have pledged to follow in order to create an atmosphere of trust, safety and respect necessary for you to achieve optimal change and mental health functioning throughout the treatment process.

1) **Attendance:** The following rules of attendance will be maintained throughout treatment. These guidelines exist because maintaining boundaries and appointments are important skills:

   - I will hold an appointment slot for no more than 15 minutes after the start time, but I can only guarantee the original time slot allotted. If you do not call at least one hour before your appointment time, **you will be charged $35. If you do not call within an hour before, and the reason is not an emergency, the appointment will be counted as a No-Show, and you will be charged a $50 fee for the missed appointment. Please note: insurance benefits do not cover missed or late cancellation fees and these will be billed to you.** After 3 No-Shows, I may provide you a referral to another provider.

   - Occasional, infrequent cancellations will be respected and understood; however, if they become common, your progress towards treatment goals will be compromised and you may be discharged with a referral to another therapist who may be better able to meet your scheduling needs. As your therapist is also human, occasionally, though infrequently, a reschedule may be asked of you should emergencies arise. You will not be charged any fee for an appointment changed at the request of your therapist.

   - You will be expected to commit to the agreed upon time period of therapy sessions and therefore not schedule any other personal or professional appointments during scheduled therapy sessions or leave sessions early for other appointments. Doing so may result in discharge with referral.

2) **Treatment Fees:** You are expected to pay your agreed upon portion ($______ for intake and $______ per session) of therapy services fee. If you are unable to continue paying this fee—or if you lose your health insurance coverage—please let me know immediately. If you do not pay your agreed upon fee for services rendered, treatment will be suspended until your bill can be paid in full. If you continue not to pay a therapy bill that is overdue, that bill will be sent to a collection agency and you will be discharged with a referral.

   - **Credit card fee**: A fee of 2.85% will be added to all authorized, swiped credit card transactions and 3.85% to all manually entered transaction to cover the bank processing fee. No fee will be added to cash or check transactions.

   - **Returned checks**: You will be charged the full fee for any checks returned by the bank and services will be suspended until the owed amount is paid in full. If two checks are returned, checks will no longer be accepted and you will have the choice of cash or credit card to pay for future services rendered.

   - **Court and legal correspondence**: Therapy is successful due in large part to the privacy allowed by the boundaries of confidentiality. Therefore, I do not go to court for clients. By signing this agreement, you are agreeing not to call me into court proceedings. If a judge were to require my participation in court proceedings of the client's case, you will be charged a $2500 retainer to be paid up front. I charge $200 per hour which will include any preparation, correspondence, time spent in court and time driving. You will also be billed for any lodging expenses if required. You will be billed or reimbursed accordingly when services have been completed.

   - **Information sharing fee**: If you request through a written authorization that I share any information that I share any therapeutic information (including but not limited to a summary of the client record or an application for disability benefits) you may be charged a fee of $25 per 15 minutes spend preparing the requested information

   - **Assessments**: If assessments are conducted per client request, the cost of the assessment will be the responsibility of the client and time spent processing the assessment results will be charged at a rate of $25 per quarter hour.

3) **If the client is a minor** or **adult under legal guardianship**, I am legally qualified to authorize mental health treatment of the client,

   ____, because:
   (client's name)

   _____ I am the sole legal guardian of the above referenced child or adult and I am solely responsible for authorization of all mental health evaluation and treatment for my child or charge.
   _____ I have joint legal custody of the above referenced child or adult and share rights to authorize mental health evaluation and treatment choices made for my child or charge.

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4) **24/7 Coverage Plan:** Confidential voicemails may be left at my work number 24/7, though I may not return calls until my next available business day. Messages will be returned between 8:30 a.m. and 5:30 p.m. Monday through Friday unless I am not in my office that day due to training, illness or vacation, in which case I will record an extended absence greeting that will instruct you in how to proceed. When I am ill or on vacation, I do not check messages until my first business day of my return.

- **Emergencies:** I do not have a receptionist and, even during office hours, cannot always answer calls immediately; therefore, if an emergency occurs outside of the regularly scheduled appointment time, please call 911 or go to the nearest emergency room. If you are hospitalized or admitted for residential treatment, please give the staff my contact information as soon as possible. I will contact you if illness or planned absences prevent me from attending regular appointments or from checking correspondence. In this case, I will develop an individualized plan with you to maintain safety and/or continue to receive therapy services during the course of my absence.

- **Text messaging and e-mail:** Calls will be made to all of the numbers authorized in your intake forms or through releases of authorization forms, including live phone calls, voicemails and text messages. Understand that text messaging is not a secure form of communication and should only be used for communicating quick information regarding scheduling, confirming or cancelling appointments. Also, I can only guarantee a response to your message 8:30 a.m. to 5:30 p.m. Monday through Friday. My phone is unable to send an out-of-office text; if you have texted during business hours and I have not responded within one business day, please call my business number which will have my out-of-office greeting and directives. I do not generally use e-mail for correspondence with clients with very few exceptions, which will be agreed upon in session.

5) **Electronic Records**: All client records are stored electronically in an encrypted, HIPAA-compliant format.

6) **Contact Outside of Therapy:**

- Once a therapeutic relationship has been established, it takes ethical priority over all other forms of relationships, including but not limited to friendship, working relationships and romantic relationships. Therefore, I will not engage in any dual relationship with you, or any of your loved ones, that may adversely affect you in any way.

- Occasionally, we may run into one another in public. Since therapy is based on confidentiality and trust, I will leave the decision to acknowledge acquaintance up to you. I will simply smile, and if you do not wish to even acknowledge my existence, you do not have to worry about my feelings—just remember that I am giving you permission to ignore me if you're just not feeling sociable that day. If you do want to interact, our conversation will be limited to small talk with no discussion of confidential information and you do not have to acknowledge the nature of our relationship in front of others or at all.

- If you wish to invite me to a meaningful event or give me any token of appreciation beyond your agreed upon fee—*neither of which is ever expected or required*—your gesture will be appreciated, but I will only accept if, after careful consideration and discussion, I determine that doing so will benefit you with no detriment to your progress or our therapeutic relationship.

7) **Questions about the Therapeutic Process:** Entering treatment in no way guarantees improvement in symptoms, as success has as much to do with your participation and the quality of the therapeutic relationship as it does the skill and efforts of your therapist. To ensure that treatment is effective, if at any time you do not understand or are uncomfortable with a therapeutic technique or any part of the treatment process, please feel free to discuss such confusion or discomfort with me. If, after thorough discussion, you still do not wish to pursue the intervention in question, I will work with you to develop an alternative strategy to achieve the goal. If no solution can be agreed upon or no progress is being made, I may discharge you with a referral to another therapist who may better meet your needs.

***By signing below**, I attest that I have read and understand all of the terms of this Counseling Agreement. I authorize Christina R. Perkins, LCSW, to provide counseling services to me or my child listed in Section 3 of this form and to store records of such treatment electronically. Such treatment may include, but is not limited to, individual counseling, group counseling and family counseling or other specialized counseling procedures or assessments, which are generally accepted in the treatment of the client's presenting clinical diagnosis or diagnoses and symptoms.* **My signature below indicates my full and informed consent to abide by the policies and practices described in this agreement.**

Client/Guardian Name:____

Client/Guardian Signature: ____ Date:____/____/____

Therapist Signature:____ Date:____/____/____