Julie Wells M.S.W., L.C.S.W., C.P., P.A.T.

To Help Us Work Well Together

In order for us to work most effectively together, I have found it is important to define the following:

Cancellation

The appointments, which you make at this office, are at times reserved exclusively for you. If for any reason you need to cancel, *please call no later than 24 hours prior to your appointment*. In the event that you cannot cancel 24 hours in advance, you will be charged $50 for the missed appointment. This charge is not billable to insurance. If you neither cancel nor appear for your appointment, you are responsible to pay the full fee for the missed appointment. If you fail to attend, without proper notification, two scheduled appointments in a row, I also reserve the right to discontinue service. Please initial if you understand this policy__________________________.

Payment

Payment, or co-pay, is requested at the beginning of each session unless otherwise arranged. If this creates a problem, I am willing to discuss alternative payment arrangements (Please complete the income disclosure form). Please refer to the Fee Policy & Agreement for complete information. The fee may be met with cash, personal check, or money order.

Tardiness

Each individual session is 50 minutes long (couples/family sessions 50-80 min./group 120 min), which begins at your scheduled appointment time. Your fee is based on that time period. Prompt arrival for your appointment is in your best interest.

I understand and accept this policy.

Name of Client (please print) Signature

____________________________________ ____

Date of Birth___________________ Today's Date_________________________

Receipt and Acknowledgment of Notice of Privacy Practices

Confidentiality is one of the most important components between a client and therapist. Successful therapy requires a high degree of trust with highly sensitive subject matter that is usually not discussed anywhere but during the session. You can expect that what you discuss in session will not be shared with anyone except when state law, HIPAA, and professional ethics require exceptions. The following situations are required exceptions to confidentiality:

* Suspected past or present abuse or neglect of children, adults, and elders.
* If the therapist has reason to suspect the client is seriously in danger of harming him/herself or has threatened to harm another person.

Anyone engaging in treatment needs to read Journey Into Wellness Counseling Services LLC *Notice of Privacy Practices*. **Once read, please ask any questions necessary to fully understand this information. This is called "informed consent".**

Client Name:____

Date of Birth: ____

I hereby acknowledge that I have been given an opportunity to read a copy of Journey Into Wellness Counseling Services LLC, Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Julie Wells BS, MSW, LCSW, CP at 727-688-5800 or 2641 Harbor Circle Clearwater, FL 33759. I will request a copy of this policy if needed.

____

Signature of Client Date

____

Signature or Parent, Guardian or Personal Representative Date

____

Signature of Therapist Date

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Income Disclosure Form (Optional-- only to be filled out if you would like to be consider for a sliding scale fee arrangement.)

This form is to be completed by anyone who is considered a "self pay" or not using insurance benefits and feels they would need a reduced fee for services to be afforded. Journey Into Wellness Counseling Services LLC offers this consideration voluntarily because of the commitment to human rights and social justice. Please consider that, as a small business, Journey Into Wellness Counseling has limits to what can be offered. If a fee for services cannot be agreed upon you will be given information about other community resources that may be helpful and affordable.

Income:

- Monthly gross income 1: $____________________ Form of verification: ____
- Monthly gross income 2: $____________________ Form of verification: ____
- Monthly child support payments: $_____________ Form of verification: ____
- Monthly alimony payments: $_________________ Form of verification: ____________________

Total monthly gross income $___________________ *Gross refers to before taxes and other deductibles are taken.*

Expenditures:

- Outstanding medical costs: $___________________ Form of verification: ______________________
- Yearly tuition costs: $_________________________ Form of verification: ______________________
- Monthly child support payments: $_____________ Form of verification: ____________________
- Monthly alimony payments: $_________________ Form of verification: ____________________

Total monthly gross expenditures $___________________ *Gross refers to before taxes and other deductibles are taken.*

Number of dependents in the family, including self: _______________________

I,____verify that the above information and is true and accurate. I understand that this information will be reviewed every 12 months, and if there are any income changes my fee for treatment may be adjusted. I understand that I am encouraged to discuss any changes in my financial situation as they arise.

Client Signature____Date ________________________

Fee for initial evaluation: $_____________________________
Fee for individual psychotherapy sessions: $___________________
Fee for couple/family psychotherapy sessions: $_________________
Fee for group psychotherapy sessions: $___________________________

Client Signature____Date ________________________

Therapist Signature____Date ________________________