RIVER VALLEY COUNSELING, LLC
131 North Ewing Street, Suite B
Lancaster, OH 43130-3383

CANCELLATIONS & MISSED APPOINTMENTS

All appointment cancellations require a **24-hour notice** or in the case of illness, a message prior to 8:00 am on the appointment day. Our voicemail is available 24 hours/day to take messages after hours or on the weekends if you need to cancel an appointment. Adequate notification respects the doctor/therapist's time as well as allows availability to others requesting services. Failure to not show at all or less than 24-hour notice on cancellations will result in a $35.00 charge which must be paid prior to scheduling another appointment. In addition, arriving late to appointments could also result in charges that would be equal to the time you kept your therapist waiting. Continued non-compliance in keeping your appointments can result in dismissal from the practice. *** Note to Parents – if you are financially responsible for your child, it is your responsibility to make sure you know when your child's appointments are and it is your responsibility to pay this fee if the appointment is missed.**

I HAVE READ THIS OFFICE POLICY AND HAVE BEEN OFFERED A COPY. I UNDERSTAND AND AGREE TO THE TERMS CONTAINED IN IT.

CLIENT NAME: _____ DOB: ____/____/____

_____

Client/Legal Guardian Signature **Date**

_____

Witness **Date**

RIVER VALLEY COUNSELING, LLC
131 North Ewing Street, Suite B
Lancaster, OH 43130-3383

CLIENT NAME: _____ DOB: ____/____/____

CONSENT FOR TREATMENT AND INFORMATION SHEET

The decision to begin mental health treatment is one that may have important results for your life. Research has shown that individuals entering therapy achieve more favorable results when they have a good understanding of what to expect. We have developed this sheet to provide you with an overview, but no information sheet can answer all questions, so please feel free to ask us about any questions you have.

Individual sessions usually last approximately 45 minutes providing us with time to think about what you have said, make notes, and plan your services. Your first session will usually be devoted to assessing the type and extent of the problems and concerns you have and to plan your services.

Your therapist has a responsibility to ask questions about your history, your life situation, and your current distress. Your therapist also has a responsibility to be open with you and to provide direct information about your treatment.

As a client in our office, you will also have certain responsibilities for payment and for keeping your appointments. Your most important responsibility, however, is to yourself – to work towards the goals we mutually set, and to work toward your goals both during sessions and during days between sessions. This is your time for you.

There are charges which are not covered by insurance for missed appointments and late cancellations. Please refer to the Canceled and Missed Appointment Policy form for details on these charges.

Once any charge has remained on your account for 90 days, the entire outstanding balance will be forwarded to a collection agency.

We place a high value on the confidentiality of your records. Records will typically be held confidential except as required by law, or as released by your written authorization. Please see our Notice of Privacy Practices Form for more information on this. On occasion, records may be reviewed for quality and appropriateness of care by the clinic or by your insurance company.

Entering psychotherapy requires a commitment of time, energy and resources, and often requires some courage to make the first appointment. Your commitment will be honored here and you will be treated with respect. Thank you for choosing our office.

(ADDITIONAL LANGUAGE FOR CONSENT FOR TREATMENT AND INFORMATION SHEET)

Minors

If you are under 18 years of age, please be aware that the law may provide your parents the right to examine your treatment records. Before giving parents any information, we will discuss this matter with you, if possible, and do our best to handle any objections you may have. In addition, if one parent brings a child and the therapy only involves the child, under Ohio law both parents have access to the child's records and anything the other parent says in the sessions, unless a parent is blocked by court order from obtaining information on their child, although your therapist may provide your records to another therapist if he or she believes the records could have an adverse effect on the client. Minors 14 years of age and older should be aware that they have an option to see one of us on a limited basis without their parents' knowledge, except where there is a compelling need for disclosure based on a substantial probability of harm to the minor or to other persons, and if the minor is notified of the intent to inform the minor's parent, or guardian. Only the minor is responsible for paying for services under this option.

Emergencies and After-Hours Care

We may be reached at 740-689-6700. We will make every effort to return messages within 24 hours; however, we may not always be able to do that. Current clients will be notified during sessions of upcoming travel or vacation. If you have an emergency, you should go directly to a hospital emergency department, call 911, or call the Fairfield Medical Center talk line at 740-687-TALK (8255). Emergencies are urgent situations and require your immediate action.

Incapacity or Death of Therapist

In the event that your therapist is incapacitated or dies, it will be necessary for another therapist to take possession of your file and records. By signing this form, you consent to allow another licensed mental health professional whom your therapist designates to take possession of your file and records, to provide you with copies upon request, or to deliver them to a therapist of your choice. In signing this form below, you agree that you will select a successor therapist within a reasonable time and will notify the appointed licensed mental health professional if you choose that option.

Email and Texting

We do not like to use e-mail or texting for communications. If you decide you want to utilize either form of communication, you acknowledge that there are risks inherent in such communications and you accept those risks.

Acknowledgement of Informed Consent to Treatment

I voluntarily agree to receive mental health assessment, care, treatment, or services and authorize River Valley Counseling, LLC to provide such care, treatment, or services as are considered necessary and advisable.

I understand and agree that I will participate in the planning of my care, treatment, or services and that I may stop such care, treatment, or services that I receive through River Valley Counseling, LLC at any time. I also understand that there are no guarantees that treatment will be successful.

By signing this Acknowledgement of Informed Consent to Treatment, I, the undersigned client, acknowledge that I have both read and understood all the terms and information contained herein and I agree to be bound by the provisions in this agreement. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me. If a minor is the client, I am signing on behalf of the minor as the authorized parent/guardian. (Information on Minor rights will be shared with the minor.)

I HAVE READ THE ABOVE AND UNDERSTAND AND AGREE TO MY RESPONSIBILITIES, AND CONSENT FOR TREATMENT. **IF MINOR CLIENT, PARENT/GUARDIAN ATTESTS TO HAVING LEGAL CUSTODY AND CONSENTS TO FEES AND TREATMENT BY THIS SIGNATURE.**

Client/Legal Guardian Signature **Client Name (please print)** **Date**

RIVER VALLEY COUNSELING, LLC.
131 North Ewing Street, Suite B
Lancaster, OH 43130-3383

COURT FEE SCHEDULE

- All fees charged for court activity are based on portal-to-portal travel.
- A retainer for the estimated full amount of the fee will be required one week before a court appearance.
- If actual fees exceed estimated fees, clients will be responsible for the remainder of the fee within one week of rendered services.
- Fees will be assessed in four-hour blocks.
- Amounts not used will be refunded, except as listed below.

Fee Rates

- Fees for court related activities requested more than two weeks in advance = $120 *per hour (Minimum = $480)*
- Fees for court related activities requested less than two weeks in advance = $240 *per hour (Minimum - $960)*

Cancellation Policy

- If request for court related activities is cancelled 2 weeks prior to scheduled appearance the client will be entitled to a full refund minus any time the counselor used for preparation.
- If request for court related activities is cancelled 1 week prior to scheduled appearance, the client will be entitled to a 50% refund minus any time the counselor used for preparation.
- No refund will be given for cancellations that occur within the week of the scheduled activity.
- If a counselor is subpoenaed for court related activity and the subpoena is cancelled, regardless of retainer not being submitted, the client will be responsible for the initial requested fee.

Consideration for modification of this fee schedule will be made on a case-by-case basis.

CLIENT NAME: _____ DOB: ____/____/____

CLIENT SIGNATURE **DATE**

Your signature states that you are aware of this policy and agree to its terms and conditions. **Please sign even if you feel that this will not apply to your situation.**

RIVER VALLEY COUNSELING, LLC
131 North Ewing Street, Suite B
Lancaster, OH 43130-3383

FEE SCHEDULE
All Counselors

Initial Session: $110
Individual session: $95
Family Session: $100

I have read and understand the Financial Policy and office procedures at River Valley Counseling, LLC. I agree to the cancellation/reschedule policy. I further understand I will need to make my co-pay at each visit. I acknowledge that I have either received a copy of this policy or have it available to me from the website at www.rivervalleycounseling.org .

I also understand that I have the right not to have any information sent to any insurance company, if I pay for the service in full at the time of each session.

Receipt of Notice of Privacy Practices Acknowledgement Form

I hereby acknowledge that on _____ I received, or viewed from the website, the Notice of Privacy Practices of River Valley Counseling, LLC, which sets forth the ways in which my personal health information may be used or disclosed by River Valley Counseling, LLC, and outlines my rights with respect to such information.

Please list anyone to whom we may speak in regard to appointments or payments/billing along with their relationship to you:

NAME	RELATIONSHIP
_____	_____
_____	_____
_____	_____
_____	_____

Would you like for us to leave information regarding scheduling and appointments on your voice mail/answering machine?
_____ YES _____ NO

_____
Client Name (please print)

_____ _____
Parent/Guardian Name (please print) **Client/Parent/Guardian Signature**

_____ _____
Witness **Date**