HOLISTIC COUNSELING CARE OF CINCINNATI
YAGER AND ASSOCIATES
3345 Whitfield Avenue, Suite #2
Cincinnati, OH 45220-2083
Client/Counselor Contract for Couple/Family Therapy

CLIENT NAME: _____

CLIENT NAME: _____

COUNSELOR NAME(s): _____

REFERRED TO HCCC BY: _____

Session Fee: Initial Session $165.00
Additional sessions: $150 (60-minute session) with one counselor
or $125.00 (45-minute session) with one counselor
$165 (60-minute session) with two counselors

I have been informed that Holistic Counseling Care of Cincinnati (HCCC) operates in compliance with the Federal HIPAA (Health Insurance Privacy and Accountability Act) requirements. I have received a copy of the Ohio Privacy Notice Form, a professional disclosure statement from my counselor and the document, *The Nature of Counseling*. These documents describe the scope of counseling practice, privacy policies and degree and limits of confidentiality.

I am aware of the per-session fees (listed above). I am also aware that when filing with insurance companies, HCCC is required (to process claims) to provide a diagnosis to my insurance company. I can discuss this diagnosis with my counselor if I desire this information. Clients present with various mental health goals and needs: counselors then tailor client treatment plans according to these goals and needs. My counselor and I will discuss how many counseling sessions are appropriate: this issue will be revisited and regularly assessed according to my treatment goals.

If I am using my insurance benefits, I authorize HCCC to submit my insurance claims for me and to collect the insurance payments due for the services provided. Additionally, I authorize (if applicable) HCCC to complete any requested treatment plans for my insurance or managed care company as needed. I recognize that HCCC files insurance claims electronically and is fully aware of and in compliance with all HIPAA rules and regulations. I agree to pay for each counseling session and to arrange a payment plan for any balance that I owe at the end of counseling.

I understand that a 24-hour advance notice for cancellations are required to avoid a missed session charge. In addition, I am aware that missed sessions are not billable to insurance and will be billed at a full session rate.

I have been offered time to review any information for which I needed clarification regarding this contract and office policies and procedures.

_____
CLIENT SIGNATURE/DATE

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CLIENT SIGNATURE/DATE

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COUNSELOR SIGNATURE/DATE

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COUNSELOR SIGNATURE/DATE