THE RESILIENCE THERAPY GROUP BY ROBIN PEPE, LPC, MA, M. ED

PSYCHOTHERAPIST-CLIENT SERVICES AGREEMENT (PATIENT 14 YEARS OR OLDER)

Welcome and thank you for choosing us. Psychotherapy varies depending on the personalities of the provider and patient, and the problems you are experiencing. There are many different methods your therapist may use to address the issues that you are experiencing. Psychotherapy calls for a very active effort on your part. For therapy to be most successful, you will need to do the work in and outside of our sessions.

- Treating Therapist ________________________________Today's Date _________________

CLIENT CONTACT INFORMATION

- NAME ____
- BIRTHDATE ___________________
- ADDRESS
  ____
  ____
- EMAIL _________________________________PHONE ______________________________
- CALENDAR ALERTS VIA: (Circle) TEXT EMAIL PHONE
- DO NOT SEND ALERTS __________
- HOW DID YOU HEAR ABOUT US? Website | Psychology Today | Referred by:
  ____
- REASON FOR SEEKING THERAPY
  ____
- PAST THEREAPY
  ____
- **EMERGENCY CONTACT**
- NAME ____________________________________ PHONE ____________________
  RELATIONSHIP ____________________________

PAYMENT AND INSURANCE

Payment is expected at each session. Acceptable payments include cash, personal checks, bank debit, major credit, and Health Savings Fund cards. If you choose to use a credit card, a **% .04** will be added to total amount charged.

We are in-network providers with several insurance companies including: Aetna, Cigna, Highmark, Tricare, Blue Cross/Blue Shield (non-personal choice), and United Health Care. And, as a courtesy we provide electronic submissions of out-of-network insurance plans to expedite any reimbursements that your plan may allow.

- NO INSURANCE, SELF PAY RATE $ ________________
- INSURANCE COMPANY
  ____
- MEMBER ID #
  ____
- INSURANCE IN-NETWORK RATE $________________
- OUT-OF-NETWORK RATE $ ________________

APPOINTMENT AND CANCELLATION POLICY

Session time with our clients is very important to us. We require 24-hour notification before an appointment to cancel or reschedule. Please note it is the client's responsibility, and insurance companies cannot be billed for any late cancellation/missed appointment fees. There will be a $100.00 fee for late cancellations. credit card will be kept on file and charged accordingly.

Card # ____ Security Code _____

Exp Date ___________ Zip Code _______

Receipts Emailed to __________________________ or Texted to
____

No receipt, thanks. _____

MEDICATIONS

Medication	Dosage	Frequency	Start Date

Allergies? Yes / No If yes, describe

____

PLEASE LIST ANY SUBSTANCES YOU CURRENTLY USE, IF ANY; (ALCOHOL, CIGARETTES, VAPES, ETC.)

Substance	Amount	Frequency	Age/Date Started	Date of Recent Use

NOTICE OF HIPAA PRIVACY PRACTICES

***I WAS GIVEN AND READ OR WENT OVER HIPAA LAWS WITH MY THERAPIST

Confidentiality & Privacy Policy

The law protects the relationship between a client and a psychotherapist, and information cannot be disclosed without written permission.

Exceptions include:

- Suspected child abuse or dependent adult or elder abuse, for which I am required by law to report this to the appropriate authorities immediately.
- If a client is threatening serious bodily harm to another person/s, I must notify the police and inform the intended victim.
- If a client intends to harm himself or herself, I will make every effort to enlist their cooperation in ensuring their safety. If they do not cooperate, I will take further measures without their permission that are provided to me by law to ensure their safety.

ACKNOWLEDGEMENT OF PSYCHOTHERAPIST-CLIENT SERVICES AGREEMENT

My signature below indicates that I am over the age of 14 and have read, understand and agree to the terms of The Resilience Group by Robin Pepe Psychotherapist-Client Services Agreement.

PRINT NAME____

SIGNATURE ____DATE ___________

THE RESILIENCE THERAPY GROUP BY ROBIN PEPE

Acknowledgement of Psychotherapist-Client Services Agreement

Please read, initial, sign and date the following.

________ I have read and understand the PSYCHOTHERAPIST-CLIENT SERVICES AGREEMENT, including the client's rights and responsibilities during their treatment under Robin Pepe Therapy Group LLC.

________ I have read and understand the PRIVACY PRACTICES outlined by HIPAA.

________I have read, understand and agree to the RULES OF CONFIDENTIALITY.

________ I have read and understand the 24-HOUR CANCELLATION POLICY and the client's responsibility to FEES and APPOINTMENTS.

________ I have read and understand the LIMITS TO ELECTRONIC CONFIDENTIALITY when dealing with fax, email and other electronic correspondence.

________I have been provided the opportunity to discuss the PSYCHOTHERAPISTCLIENT SERVICES AGREEMENT with my therapist, or any associate of Robin Pepe Therapy Group, LLC, and ask questions regarding this CLIENT CONTRACT and the contents within.

_____ I understand that accounts are sent to collections after 90 days if no payments are received. A 25% charge will be added to any and all accounts sent to collections.

_____I accept and approve a .04% transaction fee when using a credit or debit card

My signature below indicates that I, as a client/parent/guardian, have read the PSYCHOTHERAPIST-CLIENT SERVICES AGREEMENT, and I understand and agree to its terms. I also understand that I may request a copy of these notices.

____

Client Signature (if 14 years of age or older)   Date

If client is under the age of 14 years:

Parent/Guardian Signature ____Date_______________

Parent/Guardian Signature _______________________________________ Date ______________