LICENSE PC009298

The Resilience Therapy Group by Robin Pepe, LPC, MA, M. Ed

PSYCHOTHERAPIST-CLIENT SERVICES AGREEMENT (PATIENT UNDER 14 YEARS OF AGE)

Welcome and thank you for choosing us. Psychotherapy is a very personal experience and varies depending on the personalities of the provider and patient. There are many different methods your therapist may use to address any issues you are experiencing. Psychotherapy calls for a very active effort on your part. To be most successful, you will have to implement the strategies discussed, and do the work in, and outside, of your sessions.

Treating Therapist: _____ **Today's Date:** _____

CLIENT CONTACT INFORMATION

Patient Name: _____ **Birthdate:** _____

Address: _____

_____

* (IF PARENTS ARE DIVORCED, CONTACT INFORMATION IS REQUIRED FROM EACH PARENT)

Parent/Guardian: _____ **Relationship:** _____

Address: _____

Email: _____ **Phone:** _____

Parent/Guardian: _____ **Relationship:** _____

Address: _____

Email: _____ **Phone:** _____

How Did You Hear About Us? (Circle) Website | Psychology Today | Referral: _____

Reason for Seeking Therapy: _____

Past Therapy: _____

PAYMENT

Payment is expected at time of each session. Acceptable payments include cash, debit, credit, and Health Savings Fund (HSF) cards as well as checks made out to Robin Pepe.

NOTE: *If you choose to use a credit card, a 4% bank processing fee will be added to total amount charged.*

If you do not have insurance, you agree to a **SELF-PAY RATE** of $ _____

INSURANCE

If you have insurance: 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. Please contact your insurance company if you need pre-authorization or confirmation of benefits and coverage. As a courtesy, in addition to in-network plans, we will provide electronic submissions of out-of-network plans to expedite any reimbursements that your plan may allow.

Insurance Company: _____ **IN NETWORK** or **OUT OF NETWORK**

Member ID #: _____ **Rate $** _____

APPOINTMENT AND CANCELLATION POLICY

Session time with our clients is very important to us. We require 24-hour notice to cancel or change any scheduled appointment. Failure to do so results in a **$100 late cancellation or no show fee** that will be automatically charged to your credit card on file. This fee is the patient's responsibility and cannot be billed to insurance or paid with an HSF card.

MEDICATIONS

MEDICATION	DOSAGE	FREQUENCY	START DATE

Allergies? Yes/No. If Yes, Describe: _____

ACKNOWLEDGEMENT OF PSYCHOTHERAPIST-CLIENT SERVICES AGREEMENT / PARENTAL CONSENT

My signature below indicates that I am over the age of 14, have read, understand and agreeto the terms of The Resilience Group by Robin Pepe Psychotherapist-Client Services Agreement, and give consent for above named patient to attend psychotherapy sessions. [IF PARENTS ARE DIVORCED AND THERE IS SHARED CUSTODY OF MINOR PATIENT, THEN SIGNATURES ARE REQUIRED FROM EACH PARENT.]

Print Parent/Guardian Name: _____

Signature: _____ **Date:** _____

Print Parent/Guardian Name: _____

Signature: _____ **Date:** _____

NOTICE OF HIPAA CONFIDENTIALITY AND PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. PLEASE REVIEW THIS NOTICE CAREFULLY.

The law protects the relationship between a client and a psychotherapist. The confidentiality of the material discussed in therapy will be upheld at all times. 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.

My signature below indicates that I am over the age of 14 and have read, understand and agree to the terms of NOTICE OF HIPAA CONFIDENTIALITY AND PRIVACY PRACTICES.

Print Parent/Guardian Name: _____

Signature: _____ **Date:** _____

Print Parent/Guardian Name: _____

Signature: _____ **Date:** _____

[IF DIVORCED AND THERE IS SHARED CUSTODY OF MINOR PATIENT, THEN SIGNATURES ARE REQUIRED FROM EACH PARENT/GUARDIAN.]