Therapy Consent & Fee Agreement

This document contains important information about the professional services you will receive. Please read it carefully and write down any questions you might have so that we can discuss them. When you sign this document, it will represent an agreement between Cynthia Kok MSW, Ph.D. and yourself.

PSYCHOTHERAPY

I view psychotherapy as a partnership between us. I will use my professional knowledge and skills to help you establish therapeutic goals and identify interventions that will promote the possibility of change and growth. Psychotherapy requires active effort on your part both during and outside of sessions. You can participate by talking openly with me about who you are and your specific concerns, and by working with me to identify goals and possible solutions. Outside of therapy sessions, you may be asked to practice skills that we have identified, try out various solutions, and monitor changes. While there is no guarantee of your personal experience, psychotherapy has been shown to have benefits for people who go through it, often leading to better relationships, solutions to specific problems, and significant reductions in feelings of distress. If you are unhappy with the services I provide, please talk with me so that I can respond to your concerns. You have the right to ask questions about any aspect of the therapy process and to request a referral or to terminate therapy with me at any time.

CONFIDENTIALITY

In general, the privacy of all communications between a client and therapist is protected by law and my professional code of ethics. Apart from a few required exceptions, I will not share information about you without your written permission. State of Michigan laws require therapists to report suspected child abuse or neglect, dependent adult abuse or neglect, and threats of violence to self or others. In rare circumstances, I may be issued a valid subpoena or court order requiring me to provide specific information about you.

Please note that if you submit a request for reimbursement from your insurance company, the information I am required to provide will likely include a DSM-5 diagnosis.

There are two situations in which I might talk about part of your case with another therapist: (1) When I am away from the office for an extended time, a trusted fellow therapist may provide coverage for me, and therefore needs to know something about you. (2) To provide high-quality treatment, I sometimes consult other therapists about my clients. During a consultation, I make every effort to avoid revealing my client's identity. In both of these situations the other therapist(s) is bound by the same laws and rules as I am to protect your confidentiality.

APPOINTMENTS

Appointments are ordinarily 50 minutes in length. If you are unable to keep your appointment, it is essential that you notify me 24 hours in advance of your scheduled appointment to reschedule or cancel. You may notify me via voicemail or email. If you do not, you will be charged a full session fee for the time reserved for you. Exceptions to this include a medical or family emergency that you review with me and I approve.

RATES & PAYMENTS

My fee for a 50-minute appointment is $135. Payment is expected at the time of service unless you have made other prior arrangements with me. I accept cash, checks, credit cards, and Health Savings and Flexible Spending Account cards with major credit card logos. If you refuse to pay your debt, I reserve the right to use an attorney or collection agency to secure payment.

In addition to scheduled appointments, I charge a prorated fee based on my rate for other professional services you may need. Other services include report writing, telephone conversations lasting longer than 10 minutes, attendance at meetings with other professionals you have authorized, and preparation of records or treatment summaries. If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time plus travel time and expenses even if I am called to testify by another party. For these additional services, I will provide you with a detailed invoice at the end of each month.

If you desire to be reimbursed by your insurance company for all or part of your therapy costs, note that I am an out of network provider. You are responsible to contact your insurance company and obtain information regarding your coverage for out of network mental health benefits. I will provide you a detailed receipt of services (commonly called a superbill) at the end of each session. If you desire to obtain reimbursement from your insurance company, it is your responsibility to contact your insurance company and complete the process of reimbursement. I do not provide services based on the assumption that the charges will be paid by your insurance company. If you have additional questions regarding this process, please discuss them with me.

CONTACTING ME

I am often not immediately available by telephone. If I am unavailable, please leave a message on my confidential voice mail. You may email me for scheduling purposes or logistical questions. I do not use email to discuss or process therapy-related concerns or issues. If you are unable to reach me and you are experiencing a medical or mental health emergency, contact your physician, call 911, or go to a local emergency room. I do not provide 24-hour emergency or "on-call" coverage. If you believe you would benefit from those services I will be happy to assist you with referral.

☐ I, the undersigned, acknowledge that I have received and read this therapy agreement and understand the above information, and agree to voluntarily receive and participate in the therapeutic process with the above guidelines. I fully understand the responsibility of this agreement.

☐ I, the undersigned, agree to pay the above stated fee at the time of service.

☐ I, the undersigned, understand that all CANCELLATIONS MUST BE MADE 24 HOURS IN ADVANCE OTHERWISE A FULL CHARGE WILL BE MADE. I will be fully responsible for such charges.

_____	_____	_____
CLIENT PRINTED NAME	CLIENT SIGNATURE	DATE