The Practice of Mandy Albaugh, LMHC

Counseling Agreement

The following is an agreement between Vita Bella Counseling LLC and:

Name of Client: _____

Address: _____

City: _____ State: _____ Zip: _____

Cell 1: _____ Cell 2: _____

Okay to Leave Messages?_____ Email: _____

APPOINTMENT AGREEMENTS:

1. Counseling sessions are scheduled for 50-60 minutes. If session extends beyond 75 minutes, I understand that I will be charged appropriately.
2. I am responsible for showing up for counseling at pre-appointed time. I understand that if I am late I may not be able to have a full session, but will be charged for such.
3. I agree to give 24 hours notice for cancellation. If I provide less than 24 hour notice or fail to show for my appointment, I understand that I will be charged the following:

   Cancellation Fee (less than 24 hours notice) = **$50.00**
   No Show Fee = **$90.00**

FINANCIAL AGREEMENTS:

1. I have agreed on the following session rate of $140.00 per 55-min session, $180.00 per 90-min session, and $220.00 per 2-hour session. Any changes to this rate will need to be discussed with my counselor prior to my session.
2. I understand that monies paid in advance are non-refundable.
3. Payment is required before, or at the time, services are rendered.
4. Payment options include:
   - Cash
   - Check
   - Credit Card (Mastercard, Visa, American Express or Discover)
5. Any returned checks will be charged a $25.00 service fee.

CREDIT CARD INFORMATION:

In order for counselor to collect cancellation and no-show fees as appropriate, credit card information will be recorded below. I authorize Vita Bella Counseling, LLC to charge this card cancellation and no-show fees (see above) as appropriate. This credit card will also be used to for all fees that have been not been paid within 30 days. I will be provided a receipt for all payments upon request. This card may also be used for payment of services upon my request. I understand that I may revoke this agreement at any time by providing a request in writing.

VISA ☐ MASTERCARD ☐ DISCOVER ☐

Card # _____-_____-_____-_____

Expiration Date ___/____ Zip Code of Billing Address_____

Signature of Cardholder _____

CONFIDENTIALITY

I understand that I have a right to privacy. In other words, what is said in session with my counselor stays in the session with my counselor.
The exceptions to this are as follows:

1. I sign a written release of information, therefore, waiving my right to privacy and providing Mandy Albaugh, LMHC permission to disclose information to the person or institution that I specify.

2. My counselor receives a court order to release information and will notify me that the requested information will be released.

3. My counselor feels that I pose as a danger to myself or others. This may include but is not limited to: high risk of suicide, perpetrator of abuse or neglect of a child or elderly person, homicidal plans….

4. I am under 16 and my counselor feels that I am currently/recently a victim of rape, incest, abuse or some other crime.

LIABILITY RELEASE

I, _____, take full responsibility for my choices and
Print Name Here
behaviors during and as a result of, counseling. I release my counselor from any financial, legal, physical or psychological impact that results from my participation in counseling as well as any claim for failure on my part to produce the results I intended.

I HAVE READ, UNDERSTOOD AND ACCEPT THE TERMS OF THIS CONTRACT.

_____ _____
Signature of Partner Date

_____ _____
Signature of Partner Date