**Sarah McKnight, LMFT**
*Licensed Marriage & Family Therapist*

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# TREATMENT AGREEMENT

**FEES:** The fee per 50-minute session is $_____ (except for the first session, which is $_____). This is payable at the time of our session, unless I am billing your insurance, in which case you must pay your copayment and/or deductible at the session.

**CANCELLATION**: Sessions are by appointment only, Tuesdays through Fridays. While I strongly dislike charging for missed sessions, I do reserve that time for you. Therefore, you will be charged $_____ (not just a copayment) for missed sessions or for those cancelled without 24-hour notice, except in medical emergency. Insurance will not pay for missed sessions. If you must cancel, leave a voice mail, text and/or an email. Since your time is also valuable, if I forget a session, you get one session free.

**INSURANCE:** It is essential that you tell me about all possible insurance plans you have that might cover my services (ex. if you have Medicare in addition to a secondary policy, or coverage through your work and a family member's work). Please be aware that I will be required to provide a diagnosis on invoices and claims, and coverage may be limited to certain mental conditions. Even if you have coverage for unlimited sessions, health plans may review treatment, limit coverage, and request treatment notes. While I may check coverage for you, you are responsible for verifying and understanding the limits of your coverage. Although I am happy to assist your efforts in obtaining insurance reimbursement, I am unable to guarantee whether your health plan will provide payment for the services provided.

**If I am a provider with your plan:** I will submit claims for you, but at our session you must pay any copayment or coinsurance or any portion not covered by your plan. There may be a deductible (an amount you will need to pay out of pocket) before your plan begins coverings sessions. If insurance does not pay as expected, you remain responsible for the balance.

**If I am NOT a provider for your plan:** You will pay me in full at the session. I can give you an invoice if you wish to seek reimbursement from your plan, though many plans do not cover sessions with a provider who is not in their network.

**PLEASE SIGN THE FOLLOWING IF USING YOUR INSURANCE OR EMPLOYEE ASSISTANCE PROGRAM:**

*"I authorize the release of any information necessary (including notes, treatment summaries and diagnosis) to process insurance or Employee Assistance claims, to prove medical necessity for treatment, to request additional sessions, or to comply with mandated quality control or administrative chart reviews from the insurance plan."*

(Sign here) :**X** _____

(If applicable, second client sign here): _____

***"I authorize payment of benefits to Sarah McKnight, LMFT*** (Sign here): **X** _____

**CONFIDENTIALITY:** What you say in therapy, your records, and your attendance are all protected and kept confidential. Exceptions include when your records are subpoenaed for legal reasons, when reporting is required or allowed by law (ex. suspected child abuse or neglect, extreme danger to self, suspected elder abuse, or danger to others), when you give written permission to release information, and other exceptions outlined in my *Notice of Privacy Practices.*

**IN AN EMERGENCY**: Contact my voicemail. You may also go to the emergency room or dial 911.

**ENDINGS:** If you are unhappy with any aspect of therapy, please don't just leave – I ask that you talk to me to see if we can work it out. Even if we can't, endings usually feel better this way. Of course, you may end therapy at any time, and I am happy to assist with referrals. It is my ethical duty to provide therapy only when I feel you are actively participating and benefiting from the sessions. I may end treatment if there have been repeated no-shows, late-cancellations, repeated treatment interruptions, or for lack of payment.

**REFERRALS/GROUP:** A referral to another provider may become necessary if it becomes clear in my opinion that your issues would be better treated by a professional with different expertise. It is unethical for me to practice beyond the level of my

competence, education, training, or experience. I am not responsible for the care received from professionals to whom I refer you. Agreements made between you and I do not involve other professionals in the office suite, who each operate independent solo practices, and are not part of a group.

**PATIENT RIGHTS:** A list of your client rights is posted in the waiting room. You have the right to ask any questions about your treatment or refuse to participate in treatment at any time. This office does not discriminate in the delivery of health care services based on race, ethnicity, national origin, citizenship or immigration status, religion, gender, gender identity, age, mental/physical disability, medical condition or history, sexual orientation, evidence of insurability, or payment source.

By signing below, you acknowledge you have read this Agreement, and you acknowledge receipt of my *Notices of Privacy Practices*. My *Notice of Privacy Practices* provides information about how I may use and disclose your private health information. I encourage you to read it in full. My *Notice of Privacy* Practices is subject to change. If I change my Notice, I will give you a revised Notice. If you have left treatment, you may obtain the revised notice from me at the above address and phone number.

If you have any questions about the Notice, or any of the above, please feel free to ask.

| **X**_____ | **X**_____ | **X**_____ |
|---|---|---|
| Signature | Printed Name | Date |
| _____ | _____ | _____ |
| Signature, second client (if applicable) | Printed Name, second client (if applicable) | Date |