

Beverly J Johnson MALP

TREATMENT AGREEMENT

I have read and understand the contents of the *Information About My Practice*, which includes the following:

- Dimensions of Counseling
- Missed Appointments
- Contacting Beverly J Johnson
- Limits to Privacy/Confidentiality
- Professional Records
- Complaints
- The Health Insurance Portability and Accountability Act (HIPAA)
- Termination of Counseling
- Appointments
- Professional Fees
- Emergencies
- Treatment of Minors
- Patient Rights
- Insurance Coverage

Basic Fees

Diagnostic Intake (55-60 minutes)	\$ _____
Individual Psychotherapy (45 minutes)	\$ _____
Individual Psychotherapy (55-60 minutes)	\$ _____
Family Therapy (45-50 minutes)	\$ _____
Psychological Testing (per hour)	\$ <u>varies per test</u>
Group Therapy (per group session)	\$ <u>varies with group</u>
Other _____	\$ _____

I understand that I am responsible for the above amounts and I agree to pay these arranged charges until such time as they would be revised. I also understand that should my account become delinquent it may be turned over to a collection agency. If my account is turned over to a collection agency, I agree to pay an additional collection fee.

I understand that I am responsible to pay any charges for a missed appointment and late cancellations (unless I have given 24 hours notice, or in the case of an emergency).

I acknowledge that I have received the Notice of Privacy Practices (HIPAA form) described above and understand my rights to privacy and confidentiality and other rights and responsibilities as a client while in treatment with Beverly J Johnson MALP.

Responsible Party Signature Date