



LOVING FAMILIES

AGREEMENT for Individual, Couple and Family Sessions

- THE SESSION FEE IS DUE AT THE END OF THE SESSION AND MUST BE PAID IN FULL BY CASH OR CHECK. FEE IS \$150.00 PER ONE HOUR SESSION. IF INSURANCE IS USED, IT IS THE CLIENT'S RESPONSIBILITY TO VERIFY AND COLLECT PAYMENTS FROM THE INSURANCE COMPANY. I WILL GLADLY COMPLETE THE NECESSARY DOCUMENTATION FOR REIMBURSEMENT.
- PLEASE MAKE ALL CHECKS OUT TO: LOVING FAMILIES
- ANY ACTIVITIES CONDUCTED OUTSIDE THE THERAPY SESSION WILL BE CHARGED ACCORDING TO THE HOURLY THERAPY FEE, SUCH ACTIVITIES INCLUDE: TEACHER CONFERENCES, COURT APPEARANCES, DEPOSITIONS, OR ANY OTHER TYPE OF CONSULTATION OUTSIDE OF THE OFFICE.
- I MAKE MY CELL PHONE NUMBER AVAILABLE TO ALL MY CLIENTS AS A COURTESY AND CONVENIENCE. I WOULD GREATLY APPRECIATE IF I WAS NOT CALLED ON WEEKENDS, UNLESS THERE IS A LIFE-THREATENING EMERGENCY.
- ALL ISSUES DISCUSSED ARE CONFIDENTIAL TO THE EXTENT PERMITTED BY STATE LAW. UNDER NO CIRCUMSTANCES WILL I DISCUSS YOUR NAME AND ISSUES TO ANY OUTSIDE SOURCES WITHOUT YOUR CONSENT. THE LIMITS OF CONFIDENTIALITY ARE SUICIDE, HOMICIDE, SEXUAL ABUSE OF MINORS, AND PHYSICAL ABUSE OF MINORS. I AM REQUIRED BY LAW TO REPORT ANY BRUISES OR PHYSICAL MARKS ON CHILDREN TO THE PROPER AUTHORITIES. IF YOU HAVE ANY QUESTIONS OR WOULD LIKE TO DISCUSS YOUR RIGHTS, PLEASE FEEL FREE TO ASK ME. IT IS VERY IMPORTANT THAT YOU FEEL COMFORTABLE WITH YOUR RIGHTS AND YOUR THERAPIST.

I HAVE READ AND AGREE TO THE ABOVE STATEMENTS.

_____	_____
CLIENT SIGNATURE	DATE
_____	_____
OLGA L. BLOCH, LMFT	DATE