



COUNSELING AGREEMENT

The following is an agreement between Positive Growth Counseling, LLC and:

Name _____

Address _____

City _____ State _____ Zip _____

Phone _____ Cell _____

Email _____

Okay to leave messages? Yes No Okay to write you at home? Yes No

Emergency Contact _____

Relationship _____ Phone _____

APPOINTMENT AGREEMENTS:

1. Counseling sessions are scheduled for 50 minutes.
2. I am responsible for showing up for counseling at the scheduled 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, by phone or email. (If your appointment is on a Monday or the day following a holiday you must cancel your appointment by 5pm the previous business day to avoid penalty.) If I provide less than 24 hour notice or fail to show for my appointment, I understand that I will be charged the following:
 - One full single session rate. (If you have prepaid for sessions and have one or more remaining you will be docked one session and no additional fee will be charged.)

FINANCIAL AGREEMENTS:

1. I have agreed on the following session rate of _____.
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:
 - At time of service: Cash or Check
 - Prior to session: 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 Positive Growth 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 45 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 American Express

Card # _____ - _____ - _____ - _____ CSC (Security Code) _____

Expiration Date _____ / _____ Zip Code of Billing Address _____

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 Positive Growth Counseling, LLC 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 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.

LIABILITY RELEASE

I, _____, take full responsibility for my choices and 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 Client _____ Date _____

Signature of Counselor _____ Date _____