MELONIE GALE ~ MA LMFT LPCC LMHC NCC **melgale@msn.com**
Licensed Marriage Family Therapist #46352 **3636 Fourth Ave, St 210**
Licensed Professional Clinical Counselor #174 **San Diego CA 92103**
Licensed Mental Health Counselor #LH00003656 (WA state) **858-630-4424 Fax**
National Certified Counselor #56037 **858-429-8999**

COUNSELING AGREEMENT

Parties To The Agreement

This agreement is between **Melonie Gale MA** and undersigned **Client** for counseling/psychotherapy sessions of **forty-five (45) minutes** in length, unless otherwise discussed prior to session.

Fee For Services

The fee for the initial 45 minute session is $175. The fee for subsequent 45 minute sessions is **$115**. If additional time is requested, the fee for the additional time will be prorated at this rate. **All fees are payable in full at the time of the session unless other arrangements have been mutually agreed upon in advance.** If I am billing your insurance, payment of your deductible and copayment are due at the beginning of each session.

Missed Appointments or Cancellation of Counseling Sessions

Client agrees to pay the fee of **($60)** for any and all **missed** sessions or sessions **cancelled** with **less than 24 hours' notice**. Insurance companies do not pay for "no-shows" or late cancellations. Client agrees that this fee is due and payable within seven (7) days of the scheduled missed session or will revert to $115.

Termination of Counseling

Client has the right to request a change of counselor or terminate counseling at any time. However, termination of counseling will not serve to nullify any of the above conditions. Client agrees to bring their account current within seven (7) days of termination.

Confidentiality

Conversations between Client and Counselor will not be disclosed without your written consent except for consultations with other clinicians, unless such disclosure is required or permitted by law, including without limitation: a disclosure pursuant to court order; or a disclosure pursuant to mandatory reportable instances involving suspected abuse or neglect or exploitation; or the disclosure is necessary to protect against an existing threat of life or of serious bodily injury.

Insurance (if applicable)

Client agrees that they are responsible for all insurance information given to Counselor and that Client is responsible for knowing the insurance requirements and eligibility for therapy/counseling services. Client further agrees to pay all charges not covered by insurance for any services rendered.

Delinquent Payments

Client agrees to make all payments in a timely manner, as previously described. There will be a $35 late fee added to any balance not received or postmarked within 30 days of the due date. Client further agrees that any payments not received within 45 days of the date of service will be considered seriously overdue and will be assigned to a collection agency. There is a $35 fee for returned checks.

By signing below, Client acknowledges reading and understanding this agreement in its entirety and agreement to all foregoing terms and receipt of a copy of this agreement and Client also acknowledges receiving Therapist's Disclosure and a copy of Notice of Privacy Practices

_____

Client Signature Date

_____

Counselor Signature Date

(IF YOU ARE USING INSURANCE BENEFITS, PLEASE FILL OUT BELOW)

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR PURPOSES REQUESTED BY PROVIDER

Type of information to be Disclosed:
I hereby authorize **Melonie Gale MA** to use and/or disclose the following protected health information: All information required by client's third-party payer (Insurance Company).

Purpose and use and/or disclosure:
To determine insurance benefits coverage and eligibility for insurance benefits
Processing claims with your insurance company
Reviewing services provided to you to determine medical necessity
Utilization review activities.

Recipient of protected health information:

(Name of Health Insurance Company)

Revocation; Redisclosure
It is my understanding that this authorization can be revoked at any time, except to the extent that substantial action may have already been taken in reliance on this authorization, including provision of health care services requiring subsequent disclosure to effectuate payment. Unauthorized redisclosure by recipient is a potential risk.

Duration
If not previously revoked, this authorization will expire upon termination of therapy and full payment of all claims. Except as to third-party payers, this authorization does not include disclosure for future health care services received more than ninety (90) days from date of last signature.

This authorization covers protected health information of: (Self or other)

Signature **Date**

Signature below authorizes use and/or disclosure of protected health information in accordance with the foregoing from the date of the signature (initial or renewal).
I understand that I have the right to refuse to sign this authorization. (Insurance Client)

Signature **Date**