

Curtis J. Birky, Ph.D.

Licensed Masters Social Worker

Glenn, MI: 7139 114th St. , Glenn, MI Phone & Fax: 269-227-0004

South Bend, IN: 2420 Viridian Drive, South Bend, IN Phone: 574-234-8077

Mail: PO Box 331, Glenn, MI 49416

Regarding Emergency Services:

I run a small, solo practice and therefore do not have emergency services available. If you are actively suicidal or experiencing suicidal ideation, or if you anticipate frequent crisis, an agency setting that has 24 hour emergency service available would be a more appropriate setting for your therapy.

In all matters however, you can attempt to reach me at the following numbers:

Glenn Office: 269-227-0004

South Bend Office: 574-234-8077

During regular office hours I check these numbers frequently.

I read and understand the above limitations of services at this office:

Signed _____ Date _____

Signed _____ Date _____

Court Case Involvement:

If you ever become involved in a divorce or custody case, or any other court case I want you to understand and agree that I will not provide evaluation or expert testimony in court. You should hire a different mental health professional if those services are needed. This position is based on two reasons: 1. The testimony or evaluation changes the nature of our therapeutic relationship, and I must preserve that relationship first and, 2. My statements may be seen as biased in your favor because we have a client/therapist relationship.

I understand and will abide by this statement:

Signed _____ Date _____

Signed _____ Date _____

Copy to Client Original to Client

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Confidentiality: State laws protect the confidentiality of most topics you will discuss with your therapist during treatment. There are, however, two areas of information not considered confidential, in fact, they even require disclosure to authorities by your therapist. The first is suspected abuse of a child, or of an elderly or disabled person and the second is your therapist's belief that you may seriously harm yourself or someone else. Additionally, in certain unusual situations, a judge may demand access to your therapist's records or require your therapist to be a witness. All other information is considered protected and will not/cannot be disclosed without your permission.

Fees: You are ultimately responsible for payment of all fees at the time of service. All services are billed at \$125 per clinical hour. A clinical hour is currently defined as a 45-minute therapy session including the time your therapist needs for record keeping. Psychotherapy, preparation of letters and reports, consultation, travel time for out of office services, and telephone calls that are longer than 10 minutes are all charged at the \$125 hourly rate. Health insurance may help pay part of your expenses, depending on your plan. Your therapist will be glad to help you by filing a claim with your insurance company.

Cancellations and missed appointments: Any appointment may be canceled up to 24 hours prior to the scheduled session time. Cancellations with less than 24 hours notice or missed appointments will be billed at the full rate of \$125 per hour, since that time is lost for anyone else who might have been able to use it.

Billing statements: Statements will be mailed out on a monthly basis if there is a balance due or if you have requested a copy of your statement. You will receive a record of services rendered with their charges, a record of payments received from you or a third party, and your balance. Because an outstanding balance represents a form of a loan, a 1.5% interest charge will be added if payment is not received within 30 days of the bill being sent. If no payment has been received within 60 days, your account, unless other arrangements have been made, will be sent for collection and you will be responsible for any additional collection fees.

Since your signature below represents your acceptance of this policy and the above-mentioned conditions, please ask any questions for clarification prior to signing.

I have read this contract and agree to abide by it.

Client signature (or parent or legal guardian)

Date

Client signature

Date

___ copy to client