Richard Shannon Therapy
Rich Shannon, MA, NCC, LMFT, LCADC
www.richshannon.com
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775 560 5326
Nevada Licensed Marriage and Family Therapist #01230
Nevada Licensed Clinical Alcohol and Drug Counselor #00371-LC

AGREEMENT FOR TREATMENT AND INFORMED CONSENT

INTRODUCTION: This 4 page Agreement (hereafter referred to as Agreement) is intended to provide you (hereafter referred to as Client(s)) with important information regarding the practices, policies and procedures of Rich Shannon, Licensed Marriage and Family Therapist (LMFT), Licensed Clinical Alcohol and Drug Counselor (LCADC) (hereafter referred to as Therapist), and to clarify the terms of the professional therapeutic relationship between Client(s) and Therapist. If Client(s) has any questions or concerns regarding the contents of this Agreement please discuss this with Therapist prior to signing it. Client(s) understands that their signature on page 4 of Agreement indicates that they understand and agree to the information, policies and procedures contained in Agreement.

CONFIDENTIALITY: Client(s) understands that their signature on page 4 of Agreement indicates that they understand that what he/she says in session and over the telephone is confidential information and will not be released without his/her written consent. Client(s) understand that when therapy involves more than one person the information belongs to all Client(s) involved and will not be released unless all Client(s) agree. Client(s) understands that Therapist protects this information to the best of Therapist's ability and within what is considered reasonable. Client(s) understands that confidentiality can not be absolutely guaranteed. Client(s) understands that at a minimum the following exceptions to confidentiality exist:

1. Therapist has reason to suspect child/elder abuse/neglect.
2. Therapist has reason to suspect client is a danger to himself/herself or others.
3. When required by a court of law.

RECORDS AND RECORD KEEPING: Client(s) understands that their signature on page 4 of Agreement indicates that they understand any notes or records that Therapist creates regarding Client's contact with Therapist, Client's treatment, Client's diagnosis, Client's billing or other information recorded by Therapist are Therapist's property. Client(s) understands that under normal conditions these records will be destroyed seven years after his/her last appointment.

THERAPUETIC PROCESS: Client(s) understands that their signature on page 4 of Agreement indicates that they understand the therapy process involves the potential for both risk and benefit. Client(s) understands that during the therapy process he/she may discuss, recall and/or process difficult thoughts, memories and/or behaviors. Client(s) understands that the therapy process may create discomfort in order to achieve the goals he/she desires.

FEES: Client(s) understands that their signature on page 4 of Agreement indicates that they understand that the Therapist's fee for services is $150 per 55 minute session and that payment is required at the time of services.

INSURANCE BILLING: Client(s) understands that if prior arrangements are made that the Therapist bills insurance companies as a convenience to the Client(s) and that the Client(s) is responsible for all Therapist fees not paid by insurance providers. Client(s) understands that Therapist is not responsible for determining copays, deductibles, coverage limits etc. and that the Client(s) is responsible for being informed about the Client's insurance coverage and benefits.

Client(s) understands that their signature on page 4 of Agreement indicates that they understand and authorize the Therapist to provide information to insurance providers including diagnosis, dates of service, treatment plans and other information requested by the insurance provider.

Client(s) understands that their signature on page 4 of Agreement authorizes Therapist to receive payment from insurance providers.

Client(s) understands that their signature on page 4 of Agreement indicates that they understand and authorize the Therapist to charge the credit card on file for all charges not paid by their insurance provider within 30 days of Therapists mailing of bill for services. Client's initials indicate that the Client(s) accepts ultimate responsibility for paying Therapist's fees.
Initials_____

ADDITIONAL SERVICES: Client(s) understands that their signature on page 4 of Agreement indicates that they understand that Therapist does not normally appear in court on Client's behalf. Client(s) further understands that Therapist does not normally produce letters, reports or other requests. Client(s) understands that if Therapist is subpoenaed and court ordered to appear on Client's behalf that Client(s) will pay the above rate as an hourly fee for travel, preparation and time spent in court. Client(s) understands that if Therapist does produce letters, reports or other requests that the above rate will be charged as an hourly fee for time spent in this process.

CANCELATIONS: Client(s) understands that their signature on page 4 of Agreement indicates that they understand that cancelations must be made 48 hours in advance of scheduled appointments by phoning Therapist at 775 560 5326. Client(s) understands that failure to provide Therapist with cancelation notice may result in termination of services.

Client(s) understands that their signature on page 4 of agreement indicates that they understand and agree that Client's initials indicate that Client(s) agrees to allow Therapist to charge the credit card on file if Client(s) fails to cancel his/her appointment with a 48 hour notice.
Initials_____

Name on card_____

Card Type_____ Card Number_____

Expiration Date_____ Security Code_____ Billing Zip_____

APPIONTMENT REMINDERS: Client(s) understands that their signature on page 4 of Agreement indicates that Client(s) understand that by initialing below Client agrees to accept appointment reminders as indicated:

Initials_____ (Circle preference) By email, text message, voice message, no reminders at:

_____

EMERGENCIES AND THERAPIST AVAILABILITY: Client(s) understands that their signature on page 4 of Agreement indicates that Client(s) understands that Therapist is only available to Client(s) during Client's scheduled appointment times and that Therapist is NOT available on a 24 hour, on call or emergency basis.

Client(s) understands that their signature on page 4 of Agreement indicates that Client(s) understands that Therapist can be reached at 775 560 5326, that this is a cell phone and that Therapist will within reason attempt to protect Client's confidentiality regarding any messages Client(s) leaves.

Client(s) understands that their signature on page 4 indicates that they understand and agree that Therapist will attempt to return any calls within 24 business hours and that Client(s) understands that 775 560 5326 IS NOT an emergency number.

Client(s) Contact Information:

Name(s)_____

Address_____

_____

Primary phone_____ Insured's date of birth_____

Client(s) understands that their signature on page 4 of Agreement indicates that they understand and agree that it is acceptable to leave information on the above numbers that may indicate or reveal the therapeutic relationship Client(s) has/have with Therapist.

Emergency contact_____

Client(s) understands that their signature on page 4 of Agreement indicates that they understand and agree that if Therapist has a need to contact the above noted individual(s) in the case of an

emergency during or related to therapy involving Client(s), Client(s) grants Therapist permission to release information as Therapist deems appropriate to the situation.

List current prescription medications and/or existing health issues_____

_____

_____

List any prior therapy experiences_____

_____

List any specific goals you have for our time together_____

_____

_____

AKNOWLEDGEMENT BY CLIENT: Client(s) understands that their signature on page 4 of Agreement indicates that they understand the office practices of Therapist as described in Agreement, the Therapist standing as a LMFT/LCADC and Client(s) agrees to abide by the terms of the Agreement and to participate in therapy.

Client(s) understands that their signature on page 4 of Agreement indicates that they understand and agree that all questions related to Agreement were answered to his/her satisfaction.

Client(s) understands that their signature on page 4 of Agreement indicates that they understand and agree to hold Therapist (Rich Shannon, LMFT/LCADC) free and harmless from any claims, demands or suits for damages whatsoever, save negligence that may result from therapy services.

Printed Client Name(s)_____

_____

Client Signature(s)_____

_____

Date_____