Creative Couples and Counseling PLLC

Informed Consent

Terri Burns is a Licensed Marriage and Family TherapistTerri Burns is the owner of Creative Couples and Counseling, PLLC. Terri Burns is also an employee of Creative Couples and Counseling, PLLC.

**Confidentiality:** I am committed to confidentiality to the fullest extent allowed by Texas law. You should also know that there are certain situations in which I am required by law to reveal information obtained during therapy to other persons or agencies **without your permission.**

Also, I am not required to inform you of my actions in this regard. These situations include but are not limited to the following: (a) If you threaten bodily harm or death to yourself or another person; (b) If a court of law issues a legitimate court order (signed by a judge), I am required by law to provide the information specifically described in that order; (c) If you reveal information relative to child abuse, child neglect, or elder abuse (past or present), I am required by law to report this to the appropriate authority; (d) If you are in therapy by order of a court of law, the results of the treatment ordered must be revealed of the court; (e) Any sexual improprieties by a former therapist must be reported to the AAMFT Ethics Committee. The ethical code of marriage and family therapy prohibits dual relationships between clinician and patient and former patients. This means as our client we cannot meet with you for social occasions or be involved in any business activities with you other than providing psychotherapeutic services.

**Risk to Treatment:** The goals of therapy are to provide information, emotional support, and skills to improve personal effectiveness, preserve personal safety, and to develop problem solving strategies to deal with current problems. Psychotherapy has both benefits and risks. Psychotherapy has been shown to produce significant improvements in emotional well-being, family and personal relationships, and work and school performance. Risks include experiencing uncomfortable levels of feelings like frustration, sadness, guilt, and loneliness. Although therapy can be a powerful life changing process, there are no guarantees about what will happen. Therapy has a natural process to it, which includes a beginning (getting acquainted, identifying problems, setting goals), a middle (treatment activities-exploring approaches, developing solutions), and an ending (evaluation of goal attainment, after care goals, closure activities). We hope that you will see therapy through all of these phases.

**Duty to Warn:** In the event that the undersigned therapist reasonably believes that I am a danger, physically or emotionally to myself or another person, I specifically consent for the

Creative Couples and Counseling PLLC therapist to warn the person in danger and to contact the following persons, in addition to medical and law enforcement personnel:

**Name Telephone Number**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ I consent for\_\_\_\_ the undersigned therapist to communicate with me by mail and by phone at the following addresses and phone numbers, and **I will IMMEDIATELY advise the therapist in the event of any change: Address Telephone Number**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Appointments & Missed Appointment Policy:** Appointments: All sessions are scheduled by appointment only. My office hours are Monday-Thursdays from 8 am-6pm.Fridays from 8-2 pm. I consider evening appointments upon request. Additional after hours fees apply to appointments after 5pm. Appointment times are based upon the current fee schedule.

**Set Repeated Appointments:** Sometimes setting up a set weekly appointment time is the best way to ensure that you will be able to get an appointment time or one that best fits your schedule. However, if you make this kind of appointment, you are committed to that time until you specifically tell me you would like to give it up. If **two** set appointments are missed, I will only be able to schedule with you on a week-to-week basis to open space for clients that need set appointment times.

**Missed Appointments:** Appointments canceled with 24 hour notice incur no fees and every effort will be made to reschedule in a timely manner. If you are unable to keep a scheduled appointment, please contact the office at (972) 277-1217 at least 24 hours in advance. Appointments missed or canceled with less than 24 hour notice will be charged $60.00. I understand that emergencies and health problems do come up and I am willing to consider them when adequate notice is not given.

**However, No-shows, last minute scheduling conflicts with other professionals, sports events, family events, generally will not be considered.**

Please note that the provider may **terminate** the counseling relationship after 2 missed appointments without calling to cancel 48 hours prior to your scheduled appointment. Additionally, any balance on the account for missed appointments must be paid prior to rescheduling an appointment.

**Legal Proceedings:** If you are currently involved or become involved with any legal proceedings, please inform me as soon as possible. It is important that we discuss how the proceedings might impact our work together.

If a client is a minor, I will need the most recent copy of the judges ruling before I can see the client. I will not be able to see the client without having a copy of the divorce decree before the first session.

If legal actions occur, you will be responsible to pay me for the following even if the subpoena is sent from the opposing side of the case; (a) the time spent for travel to/from court at the rate of **$200.00 per hour**; (b) the time spent on preparing testimony, telephone conferences with attorneys, copying client records, reports, witness time, and depositions at the **rate of $200.00 per hour;** (c)the time spent on **mediations and court appearances are billed at $1,800 per half-day and $3,200 per full-day. All fees must be paid in full prior to any work being done on the legal case.**

**So it would be double the rate for $1,800.00 per half day or $3,200.00 per day court testimony time spent in mediation. It would be double the rate of time spent traveling to and from court, as well as time spent working on the case at $300.00 per hour.**

**Communication:** Telephone Communication: If I am available I will respond by cell phone after hours and between sessions for non -emergencies for up to 10 minutes w/o charge at:(972) 277-1217. That number will also accept confidential voicemail messages. Phone calls after 10 minutes in length will be **billed at $5.00 per minute.** Please note that telephone calls will be returned the next business day.

If you find yourself facing an emergency situation, please contact **emergency services (911) immediately or go to your nearest hospital emergency room.**

**Text Messaging:** This form of communication cannot ensure confidentiality and should be reserved for merely scheduling and/or canceling appointments.

**Electronic Communication:** When I am available, I will respond to email communication. However, I cannot ensure confidentiality of any correspondence sent via email and cannot be responsible for breaches in confidentiality resulting from someone getting your password or having access to your account. Therefore **email communication** should be reserved merely for **scheduling and/or canceling appointments**. I will attempt to try to respond to emails within **two** business days.

**Records and Administrative Services:** If you request it, any part of your record in the files can be released to any person or agency you designate. These requests must be made in writing and allow 30 days to process. There is a **$100 fee to obtain a copy of your client record. Payment in the amount of $200 per hour will be charged for administrative services beyond the scope of the therapy sessions with a minimum of 30 minutes to complete a service.** These services include but are not limited to: (a) consultation with other professionals, (b) preparation of reports or correspondence, (c) phone calls lasting over 10 minutes.

**Incapacitation/death:** I acknowledge that, in the event the undersigned therapist become incapacitated or dies, it will become necessary for another therapist to take possession of my file and records. By signing this information and consent form, I give my consent to allowing a

licensed mental health professional selected by the undersigned therapist to take possession of my file and records and provide me with copies upon request or to deliver them to a therapist of my choice.

**Discontinuing Treatment/Complaints**: It is also important to understand that you are free to discontinue treatment at any time and agree to notify me immediately so that I may provide you with referrals for continued care. If at any time you wish to file a formal complaint regarding my counseling services, please contact the Texas State Board of Examiners of Professional Counselors and/or Texas State Board of Examiners of Marriage and Family Therapists, Complaints Management and Investigative Section, P.O. Box 141369, Austin, Texas 78714-1369; 1-800-942-5540.

Additionally, we have the right to terminate your treatment at any time. Some of the reasons include but are not limited to: boundary violations, noncompliance with treatment, failing to follow appointment policies and procedures, and non-payment of fees and/or services rendered. Should your therapist decide to discontinue treatment, you will be provided a referral source for another psychotherapy professional or agency.

**Consent to Treatment:** 1. I agree to enter into therapy with Terri Burns, Licensed Marriage and Family Therapist Associate under supervision by Tiffany N. Smith, LPC-S, LMFT-S, NCC. I have received a fee schedule and I agree to pay for services rendered with payment due at the conclusion of each session and no balance will be carried. I understand that if I am late to a session, the length of that session may be shortened, and I agree to pay for a full session. I understand there are additional fees for appointments after 5pm and on weekends that are my financial responsibility. 2. I understand that I can leave therapy at any time. I am contracting only to financially pay for completed therapy sessions. 3. A full 24 hour notice is required for cancellation of a scheduled session. If I do not meet this requirement, I agree to pay the $130 or 150 No-Show Fee. I understand that this will be my responsibility. 4. If I miss an appointment without prior notice and do not contact this office within 10 business days following the missed appointment, then I understand my treatment with my therapist will have terminated and my file will be closed. 5. I understand that the therapist has the right to see legal recourse to recoup any unpaid balance. In pursuing these measures, the therapist has the right to use confidential information to establish the fee claim. 6. You acknowledge that you have received and understand the Notice of Privacy Practices for this office.

Signed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Therapist:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**IF A CLIENT IS A MINOR:** I give permission for this minor child(ren) to receive counseling without a parent or guardian present. I have the legal authority to seek and grant permission for professional services for a minor child, there being no legal decree disallowing my authority t

assume such responsibility. I also agree that should my legal authority be revoked, I will inform my therapist immediately.

Name of Child:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of Child:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of Child:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of Parent or Legal Guardian:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Therapist:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Fees and Payment:** Clients or Parents/Guardians are responsible for payment for all services rendered. Payment is due by the end of each session. Payment may be made with a credit card. A completed receipt will be provided at the end of each session documenting the service delivered and fees paid. Please also be aware that there is a $150.00fee for any returned/canceled credit card charge backs/declines.

**Fees are as follows:**

**Diagnostic Evaluation/ Initial Consultation $175.00**

**Couples 150.00**

**Families 175.00**

**Individuals/ Adults 130.00**

**Children 130.00**

**After Hours Appointment Fee $20**

Third Party Payment:**I do not take insurance,** but I will be happy to provide a receipt to you to submit to your insurance company for services rendered. Additionally, your insurance company may limit the number of sessions you have available or deny coverage for the services you are

seeking help for (such as couples or family counseling). So please verify your benefits before your first appointment as you are financially responsible for any and all unpaid charges for services rendered.

Credit Card Information Please provide your credit card information you plan use to make payments on your account or for no-shows and missed appointments without giving prior notice:

Type of Credit Card (circle): American Express/ Visa/ MasterCard/ Discover Name as printed on card: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Credit Card Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expiration Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3-4 Digit Security Code on Back of Card: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Billing address for credit card:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Zip Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By my signature below, I grant Creative Couples and Counseling, PLLC, my permission to charge the account described above.

Signature Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By my signature below, I grant Creative Couples and Counseling, PLLC, my permission to charge the account described above for any outstanding balance that is 60 days past due. Signature/Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NOTICE OF PRIVACY PRACTICES Creative Couples and Counseling, PLLC. THIS NOTICE DESCRIBES HOW HEALTHCARE INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW CAREFULLY. is required by law to abide by the terms of this Notice Of Privacy Practices, allow you to review this Notice prior to granting consent, and notify you of changes/revisions to this Notice. If you believe your privacy rights have been violated, you may submit a written complaint to Creative Couples and Counseling, PLLC, or to the Secretary of Health and Human Services describing in detail the manner in which you feel your privacy rights have been violated. Creative Couples and Counseling, PLLC, will not retaliate against you in any way for filing a complaint with him, or with the Secretary. YOUR PRIVATE HEALTH INFORMATION (PHI) Each time you have contact with a healthcare provider for delivery of healthcare, a record of your contact/visit is prepared. This record, maintained in written, oral or electronic format, contains presenting signs/symptoms, results of examination and tests, diagnoses, treatment and future care. Your healthcare record is the physical property of Creative Couples and Counseling, PLLC, but you have certain rights to restrict some of the uses or disclosures of the information contained in your healthcare record. Creative Couples and Counseling, PLLC; however, has the right to use and disclose the information contained in your healthcare record in the process of providing treatment, receiving payment and performing other regular health operations such as: • Documenting and describing the care you received for legal purposes • Communicating with other healthcare providers who may be involved in your case • Educating health care professionals • Evaluating and improving the care you receive and the outcomes achieved • Billing and verification of services provided to you .

Protecting your privacy and maintaining the security of your health information is one of the most important responsibilities of Creative Couples and Counseling, PLLC. Creative Couples and Counseling, PLLC, is required by law to maintain privacy and confidentiality of your health

information, provide you with this Notice of Privacy Practices, notify you of your rights to restrict use of this information, notify you if Creative Couples and Counseling, PLLC, is unable to agree to a requested restriction, and allow you to review the Notice of Privacy Practices prior to granting consent and notifying you of changes/revisions to this Notice. Examples of disclosure of your PHI and your rights concerning PHI are continued below. If you have questions or would like additional information, contact Terri Burns, the privacy officer for Creative Couples and Counseling, PLLC, at (972) 277-1217. EXAMPLES OF DISCLOSURE OF YOUR PHI Healthcare delivery and treatment: Information obtained from you by Creative Couples and Counseling, PLLC, is documented in your record and used for the assessment, evaluation, diagnosis and treatment of your health conditions). This information is provided to other healthcare professionals, such as other physicians, specialists, hospital based providers and/or other healthcare providers following your treatment by Creative Couples and Counseling, PLLC.This information would only be provided to these individuals by your expressed consent.

Billing and Payment: Your PHI is utilized to justify the level of care delivered to you and the charges incurred for the services. This information generally accompanies the bill and is sent to our payers. Other healthcare operations:Creative Couples and Counseling, PLLC, may disclose your PHI to other individuals and businesses in order for clients to perform his day-to-day operations. These other individuals and businesses include business associates such as vendors and/or contractors used for billing and claims management. These individuals are held to the same standard of privacy and confidentiality as Creative Couples and Counseling, PLLC.

Reminders and Treatment: Creative Couples and Counseling, PLLC, may contact you to provide you with information she feels is useful or helpful to you, based on your PHI. For example, she may contact you to schedule an appointment or as an appointment reminder, to suggest alternative treatments, or to provide you with information on treatments you are already receiving. Other uses and disclosures of PHI not permitted or required by law will be made only with your written authorization. You may revoke your authorization at any time provided that the revocation is in writing, except to the extent that Creative Couples and Counseling, PLLC, has already taken action in reliance on your prior authorization. The only exception to this would be under circumstances that are life-threatening or an emergency, such as an individual being acutely suicidal or in some other way in extreme danger. Not all information provided by you to Creative Couples and Counseling, PLLC, will be recorded in a healthcare record, only that information considered by her to be critical to providing for your care. Other information regarding personal matters in your private life and affairs will not be made part of a healthcare record document. YOUR RIGHTS CONCERNING PHI - Except as otherwise provided by law, you have a right to: receive a paper copy of this Notice of Privacy Practices if you have agreed to receive it electronically; receive a confidential communications of PHI if a request is submitted to Creative Couples and Counseling, PLLC, in writing, inspect and copy PHI or records about you in a designated record set as long as the PHI is maintained in the record set; ask Creative

Couples and Counseling, PLLC, to amend PHI or records about you in a designated record set as long as the PHI or record is maintained in the record set (Creative Couples and Counseling, PLLC, is not required to change the information if she deems it to be accurate); receive an accounting of disclosures of PHI (a list of the disclosures made by Creative Couples and Counseling, PLLC, about you for reasons other than treatment, payment or healthcare operations); and request that Creative Couples and Counseling, PLLC, restrict uses or disclosures of your PHI. Though Creative Couples and Counseling, PLLC, is not required to agree to a restriction, to the extent that it does agree with your request, Creative Couples and Counseling, PLLC, may not use or disclose the protected PHI in violation of the restriction unless the information is needed to provide emergency treatment, or is otherwise permitted or required by law. Effective Date: 01/2024.

Release of Information Consent Form

RELEASE OF INFORMATION CONSENT FORM I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby authorize Creative Couples and Counseling, PLLC, to disclose or receive my protected health information including: psychotherapy notes, progress notes, case notes, billing and scheduling information, assessment and psychological testing reports, physical healthcare treatment records, and psychotherapy treatment and progress.

PLEASE CHECK

\_\_\_\_School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact person \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_Medical Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_Previous Therapist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This release shall remain in effect until such time as it is revoked in writing by me. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature of Client/Legal Representative Date of signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Client/Legal Representative Client’s Date of Birth

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expiration Date of Consent

Good Faith Estimate

Due to the "No Surprises Act'' recently passed by the Department of Health and Human Services requiring a Good Faith Estimate be provided, we are offering this document to clarify fees and to serve as a notification that as of January 1, 2024, these fees will be implemented to ensure high-quality services and uniform charges. If you receive a bill that is more than $400 over your estimated costs, you have the right to dispute the charges. For questions or information about your rights, visit www.cms.gov/nosurprises.

• Annual estimated cost of therapy for weekly couple therapy sessions= $\_\_150.00\_\_\_\_x 50 sessions accounting for vacations and holidays for an estimated total of $\_\_7500.00\_\_\_\_.

• The annual estimated cost of therapy for weekly individual therapy

sessions=$\_\_130.00\_\_\_\_x50 sessions accounting for vacations and holidays for an estimated total of $\_\_\_7,000.00\_\_\_.

• Annual parent consultation monthly sessions=$\_\_\_120.00\_\_\_\_\_x12 accounting for vacations and holidays for an estimated total of $\_\_\_1440.00\_\_\_\_\_.

• This does not include no show/late fees, after hours fees, bank charges, court/litigation fees, or non-therapeutic charges.

Please note that psychotherapy services can range from a few sessions to several months, to a year or more. Additionally, the necessity to incorporate family therapy, individual therapy and parent consultations vary and is based on your therapeutic goals, overall needs, and life stressors that arise during treatment. The key is communication between you and your counselor. Please do not hesitate to ask questions or express concerns with your counselor.

\* Your signature indicates your awareness of the Good Faith Estimate, estimated annual charges and the related non-therapeutic charges outlined in this document. Your signature acknowledges your agreement to the terms of this good faith estimate for costs and services offered at Creative Couples and Counseling PLLC.

Signature Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_