Therapy Agreement and Client's Responsibilities

Wes Wilson, MA, LMFT, LAC, ACS, AAMFT Supervisor

Springs Counseling Services
4585 Hilton Parkway, Suite 202, Colorado Springs, CO 80907
Web: SpringsCounseling.com

Phone: 719-331-3338
Fax: 719-599-9001
Email: Wes@SpringsCounseling.com

"Blessed in the one who finds wisdom, the one who gains understanding…" Proverbs 3:13

Please be aware of these terms and conditions:

1. Sessions are scheduled **on the hour** and are usually **45-50 minutes** in length. If more time is needed or requested, these **additional services are subject to additional fees and are your responsibility**. **Out-of-clinic, email and mail correspondence, and phone or Skype time is billed for five minutes or more in fractions of $120/hr.**

2. **Payment is due at the time services are rendered.** Major Credit Cards, Cash, or Valid Checks are accepted. Payment should be made to "Springs Counseling Services" before the session begins. There's a **$30 charge** for returned checks, refused cards, bad or late payments. Change of payment type is subject to additional fees.

3. **You are responsible for covering the cost of your counseling**. Wes is a preferred provider with many health insurance plans. For other plans Wes is also qualified as "out-of-network". It is up to you to provide for full payment for all your services regardless of any insurance benefits or other coverage. If another person, church, or organization is helping to cover your costs, this arrangement must be confirmed prior to counseling. Church and third-party "Voucher" arrangements are accepted.

5. When you confirm a specific time for counseling you guarantee payment for that time no matter how you use it. If you miss your scheduled appointment **you will be charged for the time you have reserved** regardless (unless there is an emergency). **Cancellations must be made at least 24 hours before appointment to avoid being charged $60**.

6. Wes Wilson provides counseling in cooperation with a number of organizations, churches, courts, insurance plans, etc. If such a sponsoring third party supports your case, **you may be requested to allow the sharing of the status of your treatment and payment** to those responsible for the provision of your therapy. Wes may also consult with other qualified therapists regarding various aspects of your case on an anonymous basis.

7. As a supervisor and lead therapist, Wes may involve another therapist while serving your needs. It is possible that after a mutually agreed number of sessions, you may continue your course of therapy under the treatment of the partner therapist.

8. The **notes taken by the therapist are the personal property of the therapist** and not the client. The results of any tests administered are confidential and remain with the therapist's records. **Some tests require additional fees.**

9. All cases are confidential and secure. However, when information involves more than yourself, you may be requested to sign a release for sharing of information to and/or from other people such as spouse, family members, etc.

10. Your signature below indicates that you so affirm that you are not presently involved or currently plan to be involved in litigation that would involve any matter related to your therapeutic treatment under Wes Wilson. Since your treatment aims towards your full honesty through total personal disclosure please understand **it could be a conflict of interest if Wes Wilson MA, LMFT, LAC, ACS, were asked by a court of law to divulge your personal information before potentially hostile witnesses and attorneys not in your favor.** Wes serves you personally, not the court or others.

11. If you have any questions or would like additional information, please feel free to ask.

Version 10-23-18

I have read the preceding information, it has also been provided verbally, and I understand my rights as a client or as the client's responsible party.

_____	_____
Client/Patient Signature	Responsible Party's Signature
_____	_____
Print Client/Patient Name	Responsible Party's Name
_____	_____
Date:	If signed by Responsible Party, please state relationship to client and authority to Consent