



## **STATEMENT OF UNDERSTANDING**

Welcome to Linganore Counseling and Wellness, LLC. Our goal is to provide you with quality mental health care. Your informed consent and active participation an important part of your counseling experience. The following statements describe our agreement regarding the services and policies.

Client Information will be confidential. Information will be released only with your written permission. The ONLY exceptions are when the information is required by law (such as in cases of child abuse or immediate threat of harm to self or others) or by court order.

If the primary client is under 18 years of age, the therapist reserves the right to disclose certain information to their parents or other responsible adult if the therapist believes information may jeopardize the safety of the client or others.

If you need your therapist to go to court, the fee is \$300 per day to be on call or to appear in person. A minimum of two weeks notice is required. If there is a legal conflict over child custody or visitation, we may require that the child be assigned an attorney through the courts.

We request that you call to cancel an appointment at least 24 hours before the time of the appointment. If you not cancel or do not show up, you will be charged a \$50.00 fee as insurance does not compensate for late cancellations or no shows.

Our fee for counseling and psychotherapy is \$110 per hour unless other arrangements have been made. Your fee will be charged at each visit and is the same whether you are seen alone or with other family members.

Your signature below shows that you understand and agree with all of these statements and have been provided a copy of a Notice of Information Practices, in accord with The Health Insurance Portability & Accountability Act (HIPPA).

\_\_\_\_\_  
Signature of Client (or person acting for client)

\_\_\_\_\_  
Date

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

\_\_\_\_\_  
Relationship to client (if necessary)

I, the therapist, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative).

\_\_\_\_\_  
Signature of Therapist

\_\_\_\_\_  
Date

Copy accepted by client     Copy kept by therapist

*This is a strictly confidential patient medical record. Redislosure or transfer is expressly prohibited by law.*