Pathways Psychological Services, P.A.
PROFESSIONAL COUNSELING AGREEMENT

7575 Golden Valley Road, Suite 230
Golden Valley, MN 55427
(763) 525-8590

19230 Evans St NW, Suite 202A
Elk River, MN 55330
(763) 241-8157

For the services rendered by _____ at Pathways Psychological Services, PA ("PPS"), I agree to pay all debts for testing, counseling sessions, and other customary charges in accordance with the terms set below.

1. I acknowledge that each 50 minute counseling session will cost $135. Initial intake sessions will cost $170. Based on my gross family income, my Fee for Service is $_____. All fees are subject to review and/or change.

2. I agree to pay my copayment or my fee-for-service charge *before each appointment begins*.

3. I understand that I am personally responsible to know my insurance limits, exclusions, deductibles, and copayment structures, even though support staff does a preliminary check. I do not hold PPS responsible for insurance company errors or refusals for reimbursements for services rendered. I hereby authorize PPS to submit claims for services rendered on behalf of myself/or dependents. I also authorize my insurance benefits to be paid directly to Pathways Psychological Services, P.A. *I understand I am responsible for all services for which my insurance company will not pay.*

4. *I agree to reimburse PPS my full fee or $85 if using insurance for any session which I cancel or reschedule without 24 hours notice (not including weekends or holidays) or for which I fail to arrive. All 2 hour appointments and clients with interpretation services* ***require*** *48 hours notice (not including weekends or holidays) for cancellation or the failed fee will be doubled.* (Insurance companies will not pay for late cancellations or missed appointments.) I understand that if I miss two or more sessions without giving 24 hours notice, PPS and my therapist reserve the right to terminate our therapy relationship by letter or phone call. I also understand that if I am 20 or more minutes late to my counseling sessions two or more times, my therapist or PPS reserves the right to terminate our therapy relationship by letter or phone call.

5. I understand that at no time will an outstanding copay or fee-for-service balance of more than $300 be allowed and that therapy may be temporarily suspended or terminated until sufficient payment is received to place my outstanding balance below this amount.

6. I understand that a collection agency may be employed after my account becomes 60 days past due with the express purpose of collecting any past due debts which I might owe PPS. I also understand that other reasonable legal action may be taken to secure my payment. I agree to pay an additional 25% for collection costs, including attorney fees and costs, and to release the information needed to collect my past due bill.

7. I understand that payment for any psychological/legal report prepared is due in full *before* it will be released to me or another party.

8. I understand that my case may be discussed in supervision and consultation with PPS therapists and consulting psychiatrists, for assessment, diagnosis, and evaluation of treatment and progress.

9. I understand that my records may be released by my therapist if subpoenaed by the Court.

10. 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 therapist to warn the person in danger and contact medical and law enforcement personnel. I am also aware that the therapist, as a mandated reporter, must notify appropriate authorities if he or she suspects or is told of abuse involving children or vulnerable adults.

11. I understand that all counseling is values based, and that among the many values options available, such as secular, humanist, atheist, agnostic, new age, eastern, etc., PPS counselors represent the Christian perspective. The use of prayer, biblical references and principles, and the spiritual disciplines will be incorporated only at the direction of the client. PPS counselors will be respectful of each client's values.

12. I have read the above and understand its contents. I agree to abide by the provisions set forth above. I have been given a copy of "Clients Rights and Information" and I agree to read this information before my next counseling session, if I have not already done so.

_____	_____	_____
Client Signature	Therapist Signature	Date