♥ Informed Consent, Policies, & Financial Responsibility ♥

Counseling Relationship: While we work together, usually we will meet weekly for approximately 50-minutes sessions. This counseling relationship is a professional relationship. It should not, therefore, become a social or business relationship at any time. This would be detrimental to the purposes of counseling and would contaminate the process. As such, I would request that my clients do not invite me to social events or solicit me for business. I will do the same. If I encounter clients outside of the counseling setting, I will not acknowledge the existence of any relationship.

Effects of Counseling: At any time, you may initiate a discussion of possible positive or negative effects of entering, not entering, continuing, or discontinuing counseling. While benefits are expected from counseling, specific results are not guaranteed. Counseling is a personal exploration and my lead to major changes in your life perspectives and decision. These changes may affect significant relationships, your job, and/or your understanding of yourself. Some of these life changes could be temporarily distressing. The exact nature of these changes cannot be predicted. Together we will work to achieve that best possible results for you.

Client Right: Some clients achieve their goals in only a few counseling sessions; others may require months or even years of counseling. As a client, you are in complete control and may end our counseling relationship at any time, though I do ask that you participate in a termination session. You also have the right to refuse or discuss modification of any of my counseling techniques or suggestions that you believe might be harmful. I assure you that my services will rendered in a professional manner consistent with accepted legal and ethical standards. If at any time for any reason you are dissatisfied with my services, please let me know.

Payment of Fees: *HopeSpring* Child & Family Clinic, LLC (*HopeSpring*) operates three different payment options to meet clients' needs. **Accepted Insurance Plans:** My practice is insurance-friendly and I do my best to help you use your insurance benefits. In order to receive coverage for therapy services, insurance companies typically require a psychiatric diagnosis and will often determine the type of treatment and duration of services allowed for a specific diagnosis. Additionally, some personal information needs to be shared in order to process individual claims. HopeSpring may accept assignment of insurance after confirming coverage. However, confirmation or authorization of benefit is not a guarantee of payment for services. In the event that your insurance company rejects the claim or does not pay in full for all services rendered, you are responsible for payment in full. You are responsible for non-covered services, deductibles, co-insurance, and co-payments. You are also responsible for notifying your psychotherapist if your insurance coverage changes. I submit billing to insurances to reduce the cost to you. Please contact me for details regarding insurance panel. **Out-of-Network Insurance Benefits:** If you have Out-of-Network Benefits with any other insurance company not listed above and if you decide to use Out-of-Network benefit, you need to self-pay for your session and I will give you a receipt. Then you can submit to your insurance company and the insurance company will later reimburse you directly. Most insurance plans provide opportunity to apply for reimbursement for therapy services received from out-of-network providers. **Out-of-Pocket:** Many of my clients prefer to pay out-of-pocket and NOT use their insurance benefits. This allows such clients to fully protect all information disclosed in therapy. You should be aware that your insurance company requires me, as a contracted provider, to release information relevant to the services rendered to you. This typically includes: a clinical diagnosis, a treatment plan, or even copies of your entire clinical record. This is why to fully protect their confidentiality, many of my clients prefer to disregard their insurance benefits and pay out-of pocket.

Fees: *HopeSpring* operates on a direct payment policy if you choose to pay Out-of-Pocket or use Out-of-Network benefit. *HopeSpring* asks that you provide payment in full at the time of service. Cash or personal checks made out to Mi-Kyong Kwon are acceptable for payment. All returned checks are charged a returned check fee of $40.00.

Psychotherapy Services	Length	Fee
Diagnostic Interview	**2 hours**	**$300.00**
Individual / Family Therapy (50 min)	**50 minutes**	**$200.00**
Individual / Family Therapy (90 min)	**90 minutes**	**$300.00**
Play Therapy	**50 minutes**	**$200.00**
Parent Education / Child Parent Relationship Therapy (Filial Therapy)	**50 minutes**	**$200.00**
Group Therapy*	**Varies**	**Varies**
School Meeting	**50 minutes**	**$200.00**
School Observation	**50 minutes**	**$200.00**

***Please contact Dr. Kwon for details**

Other Services		Fee
Copy of Diagnostic Interview Report		**$ 30.00**
Additional Copies of Payment Receipt		**$ 30.00**
Additional Copies of Health Information* **		**$ 30.00**
Court Preparation, Testimony, & Related Activities	**Per hour**	**$ 300.00**

****Required Appropriate Written Authorization by the client or client's parent/legal guardian**

Confidentiality: The content of therapy sessions and written records will remain confidential. No information may be released without express written authorization by the client or client's parent. Confidentiality is a key part of the counseling relationship. It is not, however, absolute. I will discuss the ethical and legal limits of confidentiality. Some of these limits include (1) determination that the client is a danger to self or others; (2) disclosure of abuse or criminal activity; (3) an order by the court to disclose information; (4) if I am otherwise required by law to disclose information; (5) cases where the clients signs a release of information; (6) information necessary for supervision or consultation; and (7) diagnosis and dates of service shared with the client's insurance company (if billing insurance) to collect payments.

Emergency Situations: If an emergency situation for which you feel immediate attention is necessary, please contact emergency services (911) immediately, or go to your nearest hospital emergency room.

Referrals: Should the client and/or I believe that a referral would be appropriate during the course of the counseling relationship, I will take the responsibility of identifying referral services and assist in making the referral. Referrals may be made for a number of reasons, including the client's or my identifying any source of conflict in the relationship, a client need which requires a greater degree of expertise or a different area of counseling specialization, or a need for medical or psychiatric attention. Referrals will be discussed openly and the transfer completed to the best of my ability.

Licensing Board: The name, address, and phone number of the state licensing agency is: Virginia Board of Counseling, 9960 Mayland Drive, Suite 300 Henrico, VA 23233. Maryland Board of Professional Counselors and Therapists, 4201 Patterson Avenue Baltimore, MD 21215. If a conflict arises in the course of the counseling relationship, it is my desire to discuss this with the client as a part of the counseling process. It is my desire to provide services in a professional manner consistent with accepted legal and ethical standards. If the client is dissatisfied or has a complaint, I would request that he/she discuss the issue with me. If I am not able to resolve the concerns, the client has the right to contact the licensing agency noted above.

Financial Responsibility Policy: This is a statement of our financial policy. You understand that you are obligated to ensure that our fees are paid in full. We will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill. You agree that you will pay any deductible and co-payment or co-insurance as determined by your insurance plan. Those payments will be due at the time of service. Many insurance companies have additional requirements or stipulations that may affect your coverage. You are responsible for any amounts not covered or payable by your insurance. If your insurance denies any part of your claim, you agree to be responsible to pay the full balance.

Cancellation Policy: Since the scheduling of an appointment involves the reservation of time specifically for you, please note that any cancellation must be made 24 hours in advance in order to avoid incurring the customary hourly charge for the time reserved for your appointment. Sessions, which missed without this advance cancellation, will be billed at fully charge.

No Show & Late Cancellation Policy: Insurance companies do not pay for missed appointment. If you or guardian (in case of minor) do not appear for your child's or your scheduled appointment (No Show - no notice and missed appointment), or cancel with less than 24 hours advance notice (Late Cancellation), you will be charged the full fee for the session based on the above fee schedule. The fee must be paid in full before future appointments will be scheduled. Fees for the no show or late cancellation will be charged on your credit card. If you are in a situation where you cannot use a credit card, you may pay by cash only prior to your next appointment. Non-compliance to this policy, and second No Shows or Late Cancellations may result in termination of services.

Credit Card Authorization for No Show & Late Cancellation Fee

I, _____, hereby appoint the billing staff of HopeSpring Child& Family Clinic, LLC to charge No Show or Late Cancellation Fee to my credit card below:

Credit Card Type: □ VISA □ MASTERCARD □ AMEX

Name on Above Card: _____ Telephone:_____

Credit Card Number:_____

CVC:_____ Expiration Date:_____

Credit Card Billing Address:_____

I agree that I will pay for all such fees and will not hold *HopeSpring* Child & Family Clinic, LLC responsible for any actions pursuant to this agreement.

Attached to this authorization; I am enclosing a clear photocopy of both the front and rear of my credit card.

Informed Consent: I affirm that prior to becoming a client, I was given sufficient information to understand the nature of counseling. The information included the nature of the agency, the counselor's professional identify, possible risks and benefits of counseling, nature of confidentiality including legal and ethical limits, and alternative treatments available. My signature below affirms my informed and voluntary consent to receive counseling.

Minor Client: I affirm that I am the legal guardian of _____. With an understanding of the above information and conditions, I do grant permission for my child to participate in counseling.
I have read the Informed Consent, Policies, & Financial Responsibility, understand, and accept the policies described above.

_____ _____
Client or Guardian's Signature Date

_____ _____
Psychotherapist's Signature Date