Client Rights, Services, and Consent Agreement

Grace Layton, LLC 8310 Allison Pointe Blvd Suite 203C, Indianapolis, IN 46250. Ph. 317-622-6544

This Client Rights, Services, and Consent Agreement (this "Agreement") made and entered into as of _____ (the "Effective Date") by and between Grace Layton, LLC located at 8310 Allison Pointe Blvd Suite 103B, Indianapolis, Indiana 46250 ("Therapist"), and clients listed below (referred to as "Client" or collectively as "Clients").

Name of Client_____**/MI**_____**/DOB**_____**/Age**_____

Name of Parent(s) if under 18 years:_____

Address of Client: _____

Phone #:_____**. May I leave a message? Yes / No**

May I email you? Yes/No Please note email is not considered a confidential medium of communication.

Email Address: _____

In consideration of the mutual covenants contained in this agreement, the parties agree as follows:

I. SERVICES

- Therapy often gives rise to complex, sometimes painful, feelings and memories. Please share these feelings with Therapist freely and openly and ask any questions you may have about treatment.
- In order to get the most out of therapy, Therapist encourages Client(s) to actively work on things talked about inside and outside of sessions. In some cases, bringing in other family members will increase the potential effectiveness of therapy.
- There is no guarantee that services will alleviate all of Client(s)' presenting problems.
- Records produced during sessions will include diagnosis, treatment plan of care, receipts, and brief summaries of sessions as Therapist deems relevant.

II. PAYMENT AND FEES

A. PROFESSIONAL FEES
The Standard Fee for a 45-50 minute session is $100.00. This amount or the subsidy (see subsidy worksheet and fee schedule) will be charged on a prorated basis for other professional services.

B. BILLING AND PAYMENTS
Payment is expected in full at the time of service. If Client's account becomes delinquent, Clients understand that Therapist retains the right to discontinue services and refer Clients' account to a collection agency.

C. TERM AND TERMINATION
1. Clients have the right to terminate therapy even against the recommendation of Therapist at any time with no penalty
2. Therapist may discharge Clients from therapy nonvoluntarily if:
   a. Client exhibits any physical violence, verbal abuse, carry weapons, or engage in illegal acts at the therapy office

b. Client refuses to comply with stipulated program rules, refuses to comply with treatment recommendations, or does not make payment or payment arrangements in a timely manner.

D. APPOINTMENTS AND CANCELLATIONS

Standard sessions are 45-50 minutes. Once an appointment is scheduled, Clients will be expected to pay for it unless Clients provide **NO LESS THAN 24 HOURS NOTICE OF CANCELLATION** by way of phone or email communication.

III. REPRESENTATIONS AND WARRANTIES

A. REPRESENTATIONS OF THERAPIST AND CLIENTS.

Therapist and Clients represent and warrant:

1. that he/she is executing this Agreement of his/her own free will and that he/she is not under any duress or undue influence to execute this waiver;
2. that he/she has carefully read, is fully and completely informed about and clearly understands the terms of this Agreement;
3. that he/she is duly authorized to enter into this Agreement; and
4. that all information contained in this Agreement is accurate and up to date.

IV. THERAPIST COVENANTS

A. CONFIDENTIALITY AND LIMITS ON CONFIDENTIALITY

1. All communications and all records relating to therapy services are confidential and may not be disclosed without Client's written consent, except in those situations in which state law mandates otherwise. In most judicial proceedings, Client has the right to prevent Therapist from providing any information about Client's treatment. However, in some circumstances, a judge may require Therapist's treatment information and/or testimony if the judge determines that resolution of the issues demands it.

2. Therapist is obligated by law and professional ethical standards to file reports with public authorities if any of the following circumstances becomes evident:

   a. Therapist has reason to believe that the safety of Client, Therapist, or the property of Therapist's office is in jeopardy;
   b. Therapist has reason to believe Client is danger of harming self or others;
   c. Therapist has reason to believe that a child, elderly, or disabled person is or has been in danger of abuse or neglect a report must be filed with the appropriate government agency; or
   d. A court orders the disclosure of records.

3. Consultations with other professionals

   Therapist may consult with other professionals in order to give Clients the best therapy Therapist is capable of giving. Therapist will take every measure possible to keep Client's name/identity confidential.

4. Payment
   If the client chooses to bill in-network or out-of-network insurance, the insurance company will require Client and Therapist to disclose information with regard to diagnosis of Client, dates of service, and purpose of therapy and/or treatment plan.

5. Inquiries
   With the exception of the above items, Therapist will not acknowledge inquiries received about Client. Therapist will keep confidential all records and information regarding therapy, and will retain client records for seven (7) years past termination of therapy, and then destroy them.

B. ETHICAL GUIDELINES AND LICENSING REGULATIONS/CREDENTIALS

1. Therapist complies with the A.A.M.F.T code of ethics.
2. Therapist is licensed in Marriage and Family Therapy.
3. Therapist graduated from Christian Theological Seminary in 2009 with a Master of Arts in Marriage and Family Therapy. Therapist went on to receive her state license in M.F.T.

V. CLIENT COVENANTS

A. NO SECRET POLICY
Couples therapy is conducted with a no secret policy. Therapist will not hold secrets of one spouse (obtained in individual therapy) from the other.

B. IN CASE OF EMERGENCY
In the case of an emergency, go to the nearest hospital emergency room, or call 911, and then leave Therapist a message.

C. DISPUTES AND COMPLAINTS
If Clients believe their privacy rights have been violated, please contact Therapist personally to discuss Clients' concerns. If Clients are not satisfied with the outcome, Clients may file a written complaint with the U.S. Department of Health and Human Services. An individual will not be retaliated against for filing such a complaint.

D. EMERGENCY CONTACT INFORMATION - OPTIONAL
Whom may Therapist contact if there is an emergency while at Therapist's office?

_____

Emergency Contact Name Phone # Relationship to Client

VI. IN CASE OF LOSS

A. INDEMNITY: It is understood by all parties that Clients in therapy may have undiagnosed mental health issues, and Clients, as part of the consideration for this Agreement, releases and waives any right to ask for or demand damages from any Therapist party for or on account of the loss of or damage to life or property.

B. LIMITIATION OF LIABILITY: IN NO CASE SHALL THERAPIST, ITS MEMBERS, DIRECTORS, OFFICERS, EMPLOYEES, AFFILIATES, AGENTS, CONTRACTORS, OR LICENSORS BE LIABLE FOR ANY DIRECT, INDIRECT, INCIDENTAL, PUNITIVE, SPECIAL, OR CONSEQUENTIAL DAMAGES ARISING FROM THE THERAPY OR FOR ANY OTHER CLAIM RELATED IN ANY WAY TO THE THERAPY, INCLUDING, BUT NOT

LIMITED TO ANY LOSS OR DAMAGE OF ANY KIND INCURRED EVEN IF ADVISED OF THE POSSIBILITY. THERAPIST'S LIABILITY TO CLIENT(S), UNDER THIS AGREEMENT, FOR ANY CAUSE WHATSOEVER IS LIMITED TO THE AMOUNT PAID BY CLIENT(S) UNDER THE AGREEMENT.

C. RISK OF LOSS: Except in the event of willful misconduct or illegal act, Therapist is not responsible for loss of life or injury by fire, theft, injury, death, or from any other cause or any claims arising out of any activities not described in this Agreement, including but not limited to any claims arising from any injuries to persons or property caused by Client(s).

Financial Agreement: (Please initial EITHER A, B, or C as well as 1 and 2.)

A. _____ **I agree to pay the standard fee** for sessions. I understand I may bill my insurance for out-of-network reimbursement if I choose.

B. _____ **I agree to use my in-network insurance benefits** and pay my co-pay/co-insurance at each session. I understand if my insurance does not reimburse Grace Layton for any reason I will be responsible for full reimbursement of all sessions not fully paid for by insurance within 90 days. I authorize the release of any medical or other information necessary to process my claims. I also request payment of government benefits either to myself or to Grace Layton.

C. _____ **I agree to take advantage of the sliding scale** and pay $_____ for a 55 minute session. I agree the information on the Sliding Scale Worksheet is an accurate statement of my total family income.

1. _____ I understand payment is accepted in the form of cash, check, and HSA/FSA only. I understand that if my check bounces I will be charged a $30 fee.

2. _____ I understand that I will be charged my usual fee for a session if I miss an appointment or cancel an appointment less than <u>24 hours</u> in advance.

Client's signature below indicates: he/she **agrees to pay** the above stated fee agreement. Signature also indicates client has read and fully understands this Fee Agreement and is executing this agreement of his/her own free will.

Client Signature X _____ Date_____

Client's signature below indicates: Therapist and Clients have **duly executed this Agreement** as of the date indicated below.

I hereby give my consent that **(Printed name of client(s)): X**_____,

_____, _____, _____, may be treated as a client at Grace Layton, LLC.

Client Signature X_____/_____/_____

(Client, parent, or legal guardian) / Relationship to Client / Date

Therapist Signature X_____/_____

(Witness Obtaining Consent) / Date

Client's signature below indicates: client has received a copy of the **Privacy Practices**

Client Signature X _____/_____/_____

(Client, parent, or legal guardian) / Relationship to Client / Date