AGAVE STUDIO
FOR PSYCHOTHERAPY
& SPIRITUAL DIRECTION

Welcome to Agave Studio!

Agave Studio provides a unique service to Humboldt Park and the surrounding areas. Our therapists have both mental health degrees as well as specialized training to help clients achieve their optimal mental, emotional, and physical health throughout the various seasons of the their lives. We are committed to supporting you in achieving your goals to feel better and maximize your potential through individual, marital, family and group therapy as well as through educational opportunities. This document contains important information about our professional services and business policies. Please read it carefully and discuss any questions you might have about it with your therapist. Once you sign this, it will constitute a binding agreement between you and Agave Studio.

APPOINTMENTS

Therapy sessions are approximately 45-50 minutes long within the scheduled appointment hour. If you are unable to keep an appointment at the time arranged, **please notify your therapist at lease 24 hours in advance, on their preferred number _____.** You should expect to be charged for the session if you fail to notify the office within the 24-hour advance. Emergencies are always considered and no charge incurred, but canceling a session without advance can disadvantage other people who could be scheduled at that hour.

INSURANCE (Release of Information)

I hereby give permission to Agave Studio to release Protected Health Information (PHI) to my insurance carrier for reimbursement of fees. This may include data from office notes or psychology notes.

CLIENT SIGNATURE: _____ Date: _____

Name of INSURED (Please Print): _____
Note: Agave is a Medicare provider but ***not*** Medicaid**.**

INFORMED CONSENT

In order to help establish a foundation of mutual trust between client and therapist, we request that you read and sign the following informed consent form, which summarizes the responsibilities of both the therapist and the client.

I, _____, affirm that I have read and understand the information stated in this agreement. * I will discuss the goals, objectives, methods, and time frame of my treatment with my therapist, understanding that these may be modified as therapy progresses. I am aware that I have the right to refuse treatment or to terminate counseling should I choose. I understand I can discuss the nature of the treatment to be employed along with the risks and alternatives. Furthermore, I limit my therapist's use of any information, which can in any way identify me to others, unless I have given my specific written permission. I understand that the limits of

confidentiality do not include homicide, suicide, child abuse/neglect (past or present), elderly abuse/neglect, supervision or consultation with colleagues, and responses to court-ordered subpoenas. Further, I understand that according to the Patriot Act, federal officials conducting national security investigations may access my records without my knowledge.

I agree to pay for the session (or insurance co-pay) at the time of service. I agree to pay for any outstanding balances, which may be billed to me or charged to my credit card, understanding that failure to do so may result in collection action or credit bureau reporting.

At this time I consent to work toward the achievement of the objectives with my therapist. I have read and understand the HIPAA psychotherapist/client services agreement. It is without any pressure or coercion that I sign this consent.

CLIENT SIGNATURE _____Date:_____
(including minors aged 12-18)

_____/_____ _____/_____
PARENT'S SIGNATURE Date PARENT'S SIGNATURE Date
(If client is minor)

(In divorce situations, the custodial parent of the minor must sign above. In most cases, it is in the best interest of the child to notify the non-custodial parent of the counseling of minor children. When payment is required from both parents, financial information will be shared with both parents).

***The HIPAA Psychotherapist/Client services agreement was made available to me.**

FEES

The fees charged to the client are fixed and determined by the costs needed to operate our practice and are comparable to other behavioral health agencies in the community. For those without insurance coverage and are paying case for service, a discount may be available.

Category	Hourly Rate (Managed Care of Billed)	Discounted Rates (Cash paid at time of Service)
Masters Level (Individual)	$180/ initial, $130/thereafter	$130/initial, $110/thereafter
Masters Level (Family)	$180/ initial, $150/thereafter	$130/initial, $110/thereafter
Ph.D/Psy.D Level (indiv, family)	$205/initial, $180/thereafter	$170/initial, $120/thereafter
Group Rates	$25-$75	&25-$75
Practicum Student	N/A	$70