Breathe Mind Body Therapy, LLC
Joni Evans, LMFT, LCPC

Information and Agreement for Psychotherapy

Welcome to the private practice of Joni Evans, M.S., LMFT, and LCPC. I want this to be a positive and helpful experience for you and would like to begin by giving you important information that may affect your therapy experience. If you have any questions or special concerns, please feel free to discuss them with me during your first session, or any time thereafter.

Services: I am a master's degree level Licensed Marriage and Family Therapist (LMFT) and a Licensed Clinical Professional Counselor (LCPC). As such, I subscribe to the guidelines and standards of the governing boards of this profession: the Montana Board of Social Work Examiners and Professional Counselors, American Association of Marriage and Family Therapy, and the American Counseling Association. I am committed to providing therapy that will enhance the quality of life without endangerment to the client or society.

Fees for Service: First session intake appointments, which require paperwork and correspondence with your insurance company are charged at $160.00. Subsequent sessions are $136.00 for a 55-minute therapy session with five minutes of administration. Additional time will result in additional charges based on the above rate broken into 15-minute increments and may not be covered by insurance.
_____ (Initial here)

Reports and Phone Calls: There is no charge for brief phone calls to schedule appointments or report information. If a phone call becomes an intervention and/or lasts over five minutes, the regular therapy rate will apply. Similarly, there is no charge for attendance verification slips or receipts of payment, but letters to the court, and/or employers will be billed at the regular therapy rate. Insurance companies will not reimburse these charges.
_____ (Initial here)

Billing and Insurance: This office will submit claims to your insurance company if you provide the appropriate insurance information. In order to do so, a diagnosis must be made and provided to insurance. **Payment is due at the time of service; this includes co-payments and deductible payments.** Acceptable forms of payment are cash, credit card, or check. ***You understand that you are financially responsible for all charges whether or not paid by your insurance. You understand that should you default on payment of your account and collection agency services are required, all costs of collections up to 50% of the balance, including attorney/court costs will be added to the balance of your account.***
_____ (Initial here)

Missed Appointments: If you are unable to keep an appointment, please notify me by phone immediately. Please provide 25-hour prior notice if a cancellation is necessary. In order to be fair and consistent with all clients, this policy is STRICTLY enforced. Except for emergencies, any notification less than the 25-hours in advance will be subject to the full appointment fee. This policy is meant as a standard for mutual respect between the client, Joni Evans, LMFT, LCPC, and the needs of other clients. Your consideration of advance notification makes it possible to give the appointment to someone else in need. The regular session fee ($136) will be billed for each missed appointment without notice. **Clients are responsible for this cost, as it will not be billed to insurance**.
_____ (Initial here)

Confidentiality: Confidentiality is the process in which any identifying information related to your case is not discussed outside of this office and is kept in a secure area to which only Joni Evans will have access. Joni Evans (hereafter known as the therapist) consults with other professionals to enhance the services that you receive. The therapist consults regularly with other licensed professional counselors. All professionals and supervisors are bound by ethical and legal obligations to maintain confidentiality. Signing this agreement constitutes release for consultation with professionals outside of this therapy office. You must sign a release of information before any identifying information about you is given to anyone outside this office.

> **In matters of child or elder abuse or neglect, potential and/or imminent danger to self or others, or if the therapist is ordered by a court of law, the therapist has an ethical and legal obligation to inform appropriate agencies/persons and provide them with all necessary identifying information. Additionally, an exception may be made if there is outstanding debt for this therapy service.**

In the case of marriage and family therapy, therapists have unique confidentiality responsibilities because we have obligations to more than one person during this type of therapy. Information shared in individual sessions, phone conversations, or written messages may be shared with other family members who have consented to treatment in this office. Likewise, no one person may sign a release of information form for family information, all members must sign.

Email and text messages are not secure, confidential forms of communication, nor are they an appropriate medium for urgent or emergency messages. If you want email and text message communication with the therapist, such communication will be limited to scheduling and confirming appointments and you must agree to the limits of confidentially with these types of communications.

Release of Information: If you have received or are receiving therapy, psychiatric services, or treatment by a medical doctor or other professional, it is in your best interest to discuss this with your therapist immediately. Generally, I will consult with other health professionals serving you. Such consultation will take place only if you agree to the consultation and sign a consent form to release confidential information.

Therapist Absence: I may from time to time be unavailable for regular appointments due to professional or personal obligations or vacations. I will make you aware of planned absences and may provide identifying information to a backup therapist in order to aid in providing services to you.

Emergencies: In the case of a mental health emergency you may contact me at any time by leaving a message on my private voicemail (406.600.4297). While I hope to be responsive to your needs, I cannot guarantee my availability after business hours. If you cannot reach me and feel unsafe, you should contact your primary health care provider and/or proceed directly to the emergency room. You may also call the Help Center (406.586.3333) for brief intervention. I do require that you have a personal emergency contact person listed with this office.

Level of Care: Services rendered at this office are not appropriate for clients requiring intensive care. During the course of therapy, I may determine that you require a more intensive level of care and will refer you to an appropriate provider. Such referrals will be made only after consulting with you and clarifying the purposes and consequences of the referral. Under certain circumstances, I may determine that another professional may better serve your needs. I will discuss concerns with you prior to terminating treatment and referring to another professional.

Length of Treatment: Generally, the course of treatment is based upon your progress in therapy towards goals mutually established with the therapist. It is the responsibility of both you and the therapist to regularly ascertain your progress toward established goals.

Legal Issues: I am not formally trained in matters that involve the legal system. This includes divorce, competency, and custody matters. If you feel you need such assistance, I will try to refer you to a qualified provider. This does not preclude reporting and testifying in cases of child abuse or neglect as required by law. By signing this form, the client agrees to refrain from having the therapist subpoenaed or otherwise involved in the client's legal matters. In the event that I am deposed, issued a subpoena, or otherwise compelled to give testimony, it is understood that my fee will be $300.00 per hour plus travel and other related expenses. This fee will be paid by you, the client, in advance and will be subject to a 60-day cancellation policy.

Benefits/Risks: You understand that while every effort will be made for therapy to be of help, and there have been many empirical studies showing the benefits of therapy, there is NO guarantee as to the results or effectiveness of this treatment. You understand that therapy may involve discussing issues that at times may be uncomfortable. However, you also understand that this process is intended to help you personally and to help you resolve concerns within yourself and with family members, partners, and other persons. You are aware that any time you have questions about your treatment, or wish to know more about possible alternative treatments, you are able to ask this therapist. You understand that you may leave therapy at any time, although you agree to discuss the termination of therapy with the therapist at a regular therapy session.

My signature below indicates that I have read the above statements, understand their meanings, and accept their conditions. My signature below confirms that the therapist has answered all of my questions concerning psychotherapy to my satisfaction.

Client Name(s):

Client Address:

Client Phone Number:

Signature of Client Date

Signature of Parent of Minor Client Date

Signature of Therapist Date