APPOINTMENT AND FEE POLICIES FOR PSYCHOTHERAPY WITH ALTHEA LEE, LMFT, License # LMFT80127

APPOINTMENT: Sessions are scheduled for 60 minutes.

CANCELLATIONS AND MISSED APPOINTMENTS: Cancellations of appointments should be made at least 24 hours in advance. Late cancellations and "No Shows/Missed Appointment" will be charged at the full fee. If you NO Show two times for your appointment, therapy services will be terminated.

PAYMENT: Payments are expected in cash or debt at the time of each session unless other arrangements are made in advance. Payments for groups are expected at each session. Paying regularly for services prevents mount up of bills and therefore, avoids unnecessary stress. ** NOTE**You are responsible and will be charged for appointment fees if your appointment is not covered by your Medical Insurance or EAP.

PHYSICAL EXAMINATION: I strongly recommend each client obtain a thorough physical exam. This is especially important if you are suffering symptoms of anxiety or depression, headaches, weight gain or loss, or other physical symptoms, which may be biologically caused. By working together, as a team, with your physician, we can better assess how to help you deal with your particular symptoms.

CONFIDENTIALITY: All information shared in the sessions is confidential and will not be released without your written permission. The exceptions to this policy will be discussed with you and include:

1. Disclosure of the abuse of children, elders, or dependents adults;
2. Disclosure of serious intent to do harm to self or other;
3. Information to insurance companies for the purpose of obtaining reimbursement for fees;
4. Certain legal situations;
5. Disclosure of the fact of the therapy relationship should collection action ever become necessary; and
6. Case collaboration/ supervision with professional colleagues.

Minor children are also entitled to the privilege of confidentiality, although the parent is the holder of the privilege in court actions.

EMERGENCIES: If you have a need to reach me between sessions, please call me and leave a message. Unless I am out of town, I will return the call as soon as possible. Please remember you can always go to your nearest emergency room or call 911.

IF YOU HAVE ANY QUESTIONS ABOUT MY POLICIES OR ABOUT PHYCHOTHERAPY, PLEASE ASK BEFORE SIGNING BELOW. YOUR SIGNATURE INDICATES YOU READ THE POLICIES AND AGREE TO ENTER THERAPY UNDER THESE CONDITIONS.

Received and Agreed: _____ **Date:** _____

If client is a minor, I grant permission for the child to receive therapy services. I am the child's parent/ or legal guardian.

Name: _____ **Date:** _____