SUSAN VAN HORN COUNSELING LLC

2805 Millwood Avenue, Suite H, Columbia, SC 29205

803.381.0661 hello@susanvanhorncounseling.com

CONSENT FOR TELEHEALTH CONSULTATION

1. I understand that my health care provider wishes me to engage in a telehealth consultation.
2. My health care provider explained to me how the video conferencing technology that will be used to affect such a consultation will not be the same as a direct client/health care provider visit due to the fact that I will not be in the same room as my provider.
3. I understand that a telehealth consultation has potential benefits including easier access to care and the convenience of meeting from a location of my choosing.
4. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my health care provider or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
5. I have had a direct conversation with my provider, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

CONSENT TO USE THE TELEHEALTH BY SIMPLEPRACTICE SERVICE

Telehealth by SimplePractice is the technology service we will use to conduct telehealth video conferencing appointments. It is simple to use and there are no passwords required to log in. By signing this document, I acknowledge:

1. Telehealth by SimplePractice is NOT an Emergency Service and in the event of an emergency, I will use a phone to call 911.
2. Though my provider and I may be in direct, virtual contact through the Telehealth Service, neither SimplePractice nor the Telehealth Service provides any medical or healthcare services or advice including, but not limited to, emergency or urgent medical services.
3. The Telehealth by SimplePractice Service facilitates videoconferencing and is not responsible for the delivery of any healthcare, medical advice or care.
4. I do not assume that my provider has access to any or all of the technical information in the Telehealth by SimplePractice Service – or that such information is current, accurate or up-to-date. I will not rely on my health care provider to have any of this information in the Telehealth by SimplePractice Service.
5. To maintain confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend the appointment.

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me.
- That I fully understand its contents including the risks and benefits of the procedure(s).
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

CREDIT CARD AUTHORIZATION

By your electronic signature of this form, you authorize charges to your credit card through Stripe via SimplePractice for services rendered. These charges will appear on your bank/credit card statement as SUSAN VAN HORN COUNSELING LLC. You have the right to request a paper copy of this document.

I authorize SUSAN VAN HORN COUNSELING LLC to charge my credit card through Stripe. I also agree that my credit card can be charged for any session that is not cancelled at least 24 hours prior to the scheduled session.

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify SUSAN VAN HORN COUNSELING LLC in writing of any changes in my account information or termination of this authorization.

I certify that I am an authorized user of this credit card and will not dispute these scheduled transactions with my bank or credit card company as long as the transactions correspond to the terms indicated in this authorization form. I acknowledge that credit card transactions could be linked to Protected Health Information.

Notice of Privacy Practices

SUSAN VAN HORN COUNSELING LLC

2805 MILLWOOD AVENUE, COLUMBIA, SC 29260

803.381.0661 hello@susanvanhorncounseling.com

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. MY PLEDGE REGARDING HEALTH INFORMATION:
I understand that health information about you and your health care is personal. I am committed to protecting health information about you. I create a record of the care and services you receive from me. I need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this mental health care practice. This notice will tell you about the ways in which I may use and disclose health information about you. I also describe your rights to the health information I keep about you, and describe certain obligations I have regarding the use and disclosure of your health information. I am required by law to:

- Make sure that protected health information ("PHI") that identifies you is kept private.
- Give you this notice of my legal duties and privacy practices with respect to health information.
- Follow the terms of the notice that is currently in effect.
- I can change the terms of this Notice, and such changes will apply to all information I have about you. The new Notice will be available upon request, in my office, and on my website.

II. HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:
The following categories describe different ways that I use and disclose health information. For each category of uses or disclosures I will explain what I mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways I am permitted to use and disclose information will fall within one of the categories.

For Treatment Payment, or Health Care Operations: Federal privacy rules (regulations) allow health care providers who have direct treatment relationship with the patient/client to use or disclose the patient/client's personal health information without the patient's written authorization, to carry out the health care provider's own treatment, payment or health care operations. I may also disclose your protected health information for the treatment activities of any health care provider. This too can be done without your written authorization. For example,

if a clinician were to consult with another licensed health care provider about your condition, we would be permitted to use and disclose your personal health information, which is otherwise confidential, in order to assist the clinician in diagnosis and treatment of your mental health condition.

Disclosures for treatment purposes are not limited to the minimum necessary standard. Because therapists and other health care providers need access to the full record and/or full and complete information in order to provide quality care. The word "treatment" includes, among other things, the coordination and management of health care providers with a third party, consultations between health care providers and referrals of a patient for health care from one health care provider to another.

Lawsuits and Disputes: If you are involved in a lawsuit, I may disclose health information in response to a court or administrative order. I may also disclose health information about your child in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

III. CERTAIN USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION:

1. Psychotherapy Notes. I do keep "psychotherapy notes" as that term is defined in 45 CFR § 164.501, and any use or disclosure of such notes requires your Authorization unless the use or disclosure is:
   a. For my use in treating you.
   b. For my use in training or supervising mental health practitioners to help them improve their skills in group, joint, family, or individual counseling or therapy.
   c. For my use in defending myself in legal proceedings instituted by you.
   d. For use by the Secretary of Health and Human Services to investigate my compliance with HIPAA.
   e. Required by law and the use or disclosure is limited to the requirements of such law.
   f. Required by law for certain health oversight activities pertaining to the originator of the psychotherapy notes.
   g. Required by a coroner who is performing duties authorized by law.
   h. Required to help avert a serious threat to the health and safety of others.
2. Marketing Purposes. As a psychotherapist, I will not use or disclose your PHI for marketing purposes.
3. Sale of PHI. As a psychotherapist, I will not sell your PHI in the regular course of my business.

IV. CERTAIN USES AND DISCLOSURES DO NOT REQUIRE YOUR AUTHORIZATION. Subject to certain limitations in the law, I can use and disclose your PHI without your Authorization for the following reasons:

1. When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.

2. For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone's health or safety.
3. For health oversight activities, including audits and investigations.
4. For judicial and administrative proceedings, including responding to a court or administrative order, although my preference is to obtain an Authorization from you before doing so.
5. For law enforcement purposes, including reporting crimes occurring on my premises.
6. To coroners or medical examiners, when such individuals are performing duties authorized by law.
7. For research purposes, including studying and comparing the mental health of patients who received one form of therapy versus those who received another form of therapy for the same condition.
8. Specialized government functions, including, ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counter-intelligence operations; or, helping to ensure the safety of those working within or housed in correctional institutions.
9. For workers' compensation purposes. Although my preference is to obtain an Authorization from you, I may provide your PHI in order to comply with workers' compensation laws.
   10 Appointment reminders and health related benefits or services. I may use and disclose your PHI to contact you to remind you that you have an appointment with me. I may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that I offer.

V. CERTAIN USES AND DISCLOSURES REQUIRE YOU TO HAVE THE OPPORTUNITY TO OBJECT.

1. Disclosures to family, friends, or others. I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

VI. YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PHI:

1. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask me not to use or disclose certain PHI for treatment, payment, or health care operations purposes. I am not required to agree to your request, and I may say "no" if I believe it would affect your health care.
2. The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full. You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.
3. The Right to Choose How I Send PHI to You. You have the right to ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and I will agree to all reasonable requests.

4. The Right to See and Get Copies of Your PHI. Other than "psychotherapy notes," you have the right to get an electronic or paper copy of your medical record and other information that I have about you. I will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request, and I may charge a reasonable, cost based fee for doing so.
5. The Right to Get a List of the Disclosures I Have Made.You have the right to request a list of instances in which I have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided me with an Authorization. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable cost based fee for each additional request.
6. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that I correct the existing information or add the missing information. I may say "no" to your request, but I will tell you why in writing within 60 days of receiving your request.
7. The Right to Get a Paper or Electronic Copy of this Notice. You have the right to get a paper copy of this Notice, and you have the right to get a copy of this notice by e-mail. And, even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy of it.

Acknowledgement of Receipt of Privacy Notice

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. By checking the box below, you are acknowledging that you have received a copy of HIPAA Notice of Privacy Practices.

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Informed Consent for Psychotherapy

SUSAN VAN HORN COUNSELING LLC
2805 MILLWOOD AVENUE, COLUMBIA, SC 29260
803.381.0661 hello@susanvanhorncounseling.com

Informed Consent for Psychotherapy

General Information

The therapeutic relationship is unique in that it is a highly personal and at the same time, a contractual agreement. Given this, it is important for us to reach a clear understanding about how our relationship will work, and what each of us can expect. This consent will provide a clear framework for our work together. Feel free to discuss any of this with me. Please read and indicate that you have reviewed this information and agree to it by filling in the checkbox at the end of this document.

Possible Side Effects and Benefits

Seeking solutions and making choices to deal with life challenges may result in discomfort. Because counseling often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings. Making choices can also bring out the negative responses of others who may wish you would make different choices. As coping skills are challenged to pave the way for more stable patterns or choices, problems may get worse before they get better. However, should you choose to pursue the journey of psychotherapy, you may benefit in many ways. Benefits could include improved relationships (with your spouse, family, child, work, etc), finding novel solutions to long-standing problems, significant reductions of distress, modifying unproductive patterns of behavior, and more freedom to live life intentionally. If for any reason you do not believe that psychotherapy is helping, please speak with me about that so we can discuss alternative treatment options.

The Therapeutic Process

I have taken a very positive step by deciding to seek therapy. The outcome of my treatment depends largely on my willingness to engage in the therapeutic process. I understand that if therapy doesn't seem to be working, it is important to speak with my therapist about this. A referral to another therapist or to a specific service may be needed. I understand that I may terminate therapy at any time, but am encouraged to discuss it with my therapist to facilitate a more appropriate plan for discharge.

Various psychotherapy techniques may be utilized during the course of my treatment. Unless otherwise noted in writing, I hereby consent to the use of any psychotherapy techniques utilized by my therapist during the course of treatment. I will speak with my therapist if I have questions about this.

I understand that in case of an emergency, I should call 911 or go to an emergency room. I understand that Susan Van Horn does not have 24 hour emergency coverage.

Confidentiality

I understand that all information pertaining to my psychotherapy services, including knowledge that I am being seen for therapy, is strictly confidential. By law, information cannot be released in spoken or written form without my signed consent. Limitations of such client held privilege of confidentiality exist and are itemized below:

1. If a client threatens or attempts to commit suicide or otherwise conducts him/her self in a manner in which there is a substantial risk of incurring serious bodily harm.
2. If a client threatens grave bodily harm or death to another person.

3. If the therapist has a reasonable suspicion that a client or other named victim is the perpetrator, observer of, or actual victim of physical, emotional or sexual abuse of children under the age of 18 years.
4. Suspicions as stated above in the case of an elderly person who may be subjected to these abuses.
5. Suspected neglect of the parties named in items #3 and # 4.
6. If a court of law issues a legitimate subpoena for information stated on the subpoena.
7. If a client is in therapy or being treated by order of a court of law, or if information is obtained for the purpose of rendering an expert's report to an attorney.
8. Confidentiality is limited for the purposes of consultation between therapist and other practicing therapists.

If we see each other accidentally outside of the therapy office, I will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to me, and I do not wish to jeopardize your privacy. However, if you acknowledge me first, I will be more than happy to speak briefly with you, but feel it appropriate not to engage in any lengthy discussions in public or outside of the therapy office.

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Practice Policies

SUSAN VAN HORN COUNSELING LLC

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PRACTICE POLICIES

FEES AND LENGTH OF PSYCHOTHERAPY SESSIONS

An initial diagnostic evaluation (60-minute session) is $100 and all additional psychotherapy sessions (50-minute session) is $100. **Payment of fees for services is required at the end of each session.** At this time, I am able to only accept credit cards for payment. While I do not participate on any insurance panels, I am happy to provide you with a superbill which you can use to submit to your insurance. Some insurance plans may cover part of the cost of out-of-network providers, but no amount will be guaranteed; you would need to call your insurance company to inquire about your plan. Please note that insurance companies require a

mental health/illness diagnosis to pay for sessions, and if a diagnosis is given, that will be recorded into your permanent file.

REDUCED FEE POLICY

A variety of circumstances may preclude you from paying the standard fee for psychotherapy services. This reduced fee policy was developed to minimize the possibility that financial limitations become the sole barrier to receiving quality psychotherapy services. I maintain a limited percentage of my caseload for reduced fee clients. Specific requests for reduced fee therapy are evaluated based on your current need and availability for reduced fee positions.

APPOINTMENTS AND CANCELLATIONS

All appointments must be scheduled through the Client Portal on Simple Practice. Please remember to cancel or reschedule 24 hours in advance. You will be responsible for the full rate of your session if cancellation is less than 24 hours. “No-shows” will also be responsible for the full rate of the scheduled session. This is necessary because a time commitment is made to you and is held exclusively for you. If you are late for a session, you may lose some of that session time but are still responsible for payment of the full rate of the scheduled session.

TELEPHONE ACCESSIBILITY If you need to contact me between sessions, please leave a message on my voicemail. I am often not immediately available; however, I will attempt to return your call within 24 hours. If a true emergency situation arises, please call 911 or go to any local emergency room.

ELECTRONIC COMMUNICATION I cannot ensure the confidentiality of any form of communication through electronic media, including text messages. If you prefer to communicate via email or text messaging for issues regarding scheduling or cancellations, I will do so. While I may try to return messages in a timely manner, I cannot guarantee immediate response and request that you do not use these methods of communication to discuss therapeutic content and/or request assistance for emergencies. Any personal or clinical information shared via electronic communication will be saved in your file.

TERMINATION

Ending relationships can be difficult. Therefore, it is important to have a termination process in order to achieve some closure. The appropriate length of the termination depends on the length and intensity of the treatment. I may terminate treatment after appropriate discussion with you and a termination process if I determine that the psychotherapy is not being effectively used or if you are in default on payment. I will not terminate the therapeutic relationship without first discussing and exploring the reasons and purpose of terminating. If therapy is terminated for any reason or you request another therapist, I will provide you with a list of qualified psychotherapists to treat you. You may also choose someone on your own or from another referral source.

Thank you for the opportunity to provide psychotherapy services. Should you have any questions, please feel free to reach out so that we can have further discussion!

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Good Faith Estimate

Susan Van Horn Counseling LLC
2805 Millwood Avenue, Columbia, SC 29260
Ph: 803.381.0661
hello@susanvanhorncounseling.com
www.susanvanhorncounseling.com
Provider EIN: 88-3363756
Provider NPI: 1083365126

Effective January 1, 2022, a ruling went into effect called the "No Surprises Act," which requires mental health practitioners to provide a "Good Faith Estimate" (GFE) about out-of-network care to any patient who is uninsured or who insured but does not plan to use their insurance benefits to pay for health care items and/ or services.

The Good Faith Estimate works to show the cost of items and services that are reasonable expected for your mental health care needs for an item or service. The estimate is based on information known at the time the estimate was created. The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment.

You are entitled to receive this “Good Faith Estimate” of what the charges could be for psychotherapy services provided to you. While it is not possible for a psychotherapist to know, in advance, how many psychotherapy sessions may be necessary or appropriate for a given person upon the initiation of psychotherapy, this form provides an estimate of the cost of services provided. Your total cost of services will depend upon the number of psychotherapy sessions you attend, your individual circumstances, and the type and amount of services that are provided to you. This estimate is not a contract and does not obligate you to obtain any services from the provider(s) listed, nor does it include any services rendered to you that are not identified here.

Good Faith Estimate

This Good Faith Estimate is not intended to serve as a recommendation for treatment or a prediction that you may need to attend a specified number of psychotherapy visits. The number of visits that are appropriate in your case, and the estimated cost for those services, depends on your needs and what you agree to in consultation with your therapist. You are entitled to disagree with any recommendations made to you concerning your treatment and you may discontinue treatment at any time.

* Patient Name:
* Patient Date of Birth:
* Patient Address:
* Patient Phone:
* Patient Email:

Patient Diagnosis (if known/applicable): N/A

IMPORTANT: A formal diagnosis may occur after a diagnostic assessment has been completed. Your therapist will discuss, as relevant, diagnosis(es) as applicable to treatment. It is within your rights to decline a formal diagnosis. Please be aware that a formal mental health diagnosis is required by your insurance company should you choose to request a superbill to file with your insurance for possible out-of-network benefits.

The one-time fee for an initial diagnostic assessment is $125 (CPT Code 90791). Beyond this, the fee for a 50-minute psychotherapy session is $100 (CPT Code 90834) and the fee for a 60-minute psychotherapy session is $115 (CPT Code 90837). Most clients will attend one psychotherapy visit per week, but the frequency of psychotherapy visits that are appropriate in your case may be more or less than once per week, depending upon your individual needs and preference. It is also important, when determining your total estimate, to take into consideration vacations, holidays, emergencies, and sick time. Following the fee for the initial diagnostic assessment, you may project any potential future cost(s) by multiplying the session fee by the total number of sessions anticipated. This will result in your total estimated cost for mental health service(s).

If you attend therapy for a longer period, your total estimated charges will increase according to the number of visits and length of treatment.

Susan Van Horn Counseling recognizes every client's therapy journey is unique. How long you need to engage in therapy and how often you attend sessions will be influenced by many factors including:
- Your schedule and life circumstances
- Therapist availability
- Ongoing life challenges
- The nature of your specific challenges and how you address them
- Personal finances

You and your therapist will continually assess the appropriate frequency of therapy and will work together to determine when you have met your goals and are ready for discharge and/or a new "Good Faith Estimate" will be issued should the frequency of session(s) or needs change. As related, you may request a new GFE at any time in writing during your treatment.

Good Faith Estimate Disclaimer:

This Good Faith Estimate shows the costs of items and services that are reasonably expected for your health care needs for an item or service. The estimate is based on information known at the time the estimate was created. Your provider may recommend additional services that are not reflected in this Good Faith Estimate.

The Good Faith Estimate is only an estimate—actual items/ service charges may differ. The Good Faith Estimate does not include any unknown or unanticipated costs that may arise and are not reasonably expected during treatment due to unforeseen events. You could be charged more if complications or special circumstances occur. Other potential items and/ or services associated with therapy charges may include but is not limited to no show/ late cancellation fee(s), record request(s), letter writing(s), legal fee(s)/ court attendance(s), professional collaboration(s), and in-between session supports). These potential items / services and associated fee(s) are discussed further within the Informed Consent documentation and should these items / services be initiated a new Good Faith Estimate will be provided. The Good Faith Estimate does not obligate the client to obtain listed items or services.

You have a right to initiate a dispute resolution process if the actual amount charged to you substantially exceeds the estimated charges stated in your Good Faith Estimate (which means $400 or more beyond the estimated charges).

You are encouraged to speak with your provider at any time about any questions you may have regarding your treatment plan, or the information provided to you in this Good Faith Estimate. For questions or more information related to the Good Faith Estimate, visit www.cms.go/nosurprises or call (800) 368-1019. Keep a copy of this Good Faith Estimate in a safe place.

* With my signature for this Good Faith Estimate, I acknowledge that I am not obligated or required to obtain any of the listed services from this provider and that I am consenting of my own free will, free from coercion or pressure. I also understand that: - I am giving up some consumer billing protections under federal law. - I agree to pay for out-of-network care provided

by Susan Van Horn Counseling. - I may get a bill for the full charges for these items and services or must pay out-of-network cost-sharing under my health plan. - I was given notice explaining that my provider and/or practice is not in my health plan's network, the estimated costs of services, and what I may owe if I agree to be treated by this provider and/or practice. - I have received notice both verbally and written/electronically. - I fully and completely understand that some or all amounts that I pay may not count towards my health plan's deductible, co-pay, co-insurance, or out-of pocket limit. - I can end this agreement by notifying the provider and/practice in writing before receiving items and/ or services. IMPORTANT: You are not required to sign this form; however, if you do not sign, the provider and/or practice may not treat you. You have the right to choose to get care from a provider and/or practice that is within your health plan's network.
By checking this, you are eSigning this form.

Reduced Fee Agreement

PSYCHOTHERAPY REDUCED FEE AGREEMENT

A variety of circumstances may preclude you from paying the standard fee for psychotherapy services. This reduced fee policy was developed to minimize the possibility that financial limitations become the sole barrier to receiving quality psychotherapy services. Specific requests for reduced fee therapy are evaluated based on your current need and availability for reduced fee positions. Should your circumstances change and you are able to increase the amount of your payment (even incrementally), it is expected that you notify your therapist so other clients may be able to similarly benefit from reduced fees.

No-show and late cancellation fees still apply to reduced fee clients. If you no-show or cancel late on two (2) consecutive occasions without significant cause**, you will no longer be eligible to receive the reduced fee.

If you do not receive any psychotherapy for at least ninety (90) days, the reduced fee agreement will be terminated.

This reduced fee agreement will be re-evaluated every six (6) months and is subject to change based on the financial and therapeutic needs of the client.

TYPICAL FEE AMOUNT:
CPT 90791 / Initial Diagnostic Evaluation: $100
CPT 90834 / Psychotherapy, 38-52 minutes: $100

* Client Name:

* Reason for Reduced Fee: financial limitations preclude from maintaining therapeutic treatment

* Client/therapist agree upon reduced fee amount of:

Note: the agreed on reduced fee amount applies to all psychotherapy sessions offered by Susan Van Horn Counseling, LLC.

EQUAL TREATMENT: You are entitled to the full benefits of psychotherapy despite this reduced fee agreement. Your full and active participation in the therapeutic process is dependent upon your motivation for therapy and not the amount of money you are paying. Therefore, Sally Braden Counseling, LLC maintains a commitment to protect your equal status regardless of your financial situation.

I agree to notify my therapist should my financial circumstances change and I am able to increase the amount of my payment.

I understand that this agreement will be terminated should I no-show or cancel late on two (2) executive occasions without significant cause**.

I understand that this reduced fee agreement will be terminated should I not receive any psychotherapy services for a period of ninety (90) days or more.

**"*Significant cause" includes major, unforeseen events occurring within 1 business day of the scheduled appointment, such as hospitalizations, house-fires, severe accidents, deaths in the immediate family etc.*

By signing my name below, I acknowledge that I have read, understand and agree to the terms of this agreement.
By checking this, you are eSigning this form.