

**Salt Lake Marital and Family Therapy Clinic**  
**1399 South 700 East, Suite 11**  
**Salt Lake City, UT 84105**  
**(801) 521-5068**

**PROFESSIONAL SERVICES AGREEMENT**

Thank you for coming to Salt Lake Marital and Family Therapy Clinic for mental health services. Therapy is a relationship that works in part because of clearly defined rights and responsibilities held by each person. This purpose of this agreement is to clarify those rights and responsibilities, as well as the business aspects of our relationship.

<b>Fees</b>	<b>Individual, Couples, or Family Therapy</b>	<b>Email or Phone Consultation*</b>
	45-minute session      \$130.00	45-minute session      \$130.00
		<b>*pre-pay only, please</b>

**Billing and Health Insurance**

- Payment is due at the time of service by cash, check, or credit card. Fees include brief phone calls and routine paperwork.
- We are providers for many insurance panels. If we are a contracted provider under your insurance plan, we will accept the agreed upon fee from your insurance company. We will submit an insurance claim for you. If you have a deductible, a copayment, or coinsurance, you are responsible for paying those at each session.
- It is your responsibility to notify your therapist of any change in insurance coverage. You are ultimately responsible for any amount not paid by your insurance plan for any reason.
- If we are not a contracted provider under your insurance plan, we will either submit a claim to your insurance for any out-of-network benefits that are available, or we will provide you with a bill that you may submit to your insurance on your own.
- If an insurance company is paying for part of your bill, we are normally required to give a diagnosis in order to be paid. Diagnoses are technical terms that describe the nature of your problems and something about whether they are short-term or long-term problems. We may also be required to provide the insurance company with information about your treatment.
- By signing below, you authorize your insurance company to pay policy benefits directly to us. If a check is mailed to you, you are responsible for paying that amount to us at the time of your next appointment.
- Finance charges of 1 ½ % per month may be added to any accounts which are 60 days or more delinquent. There will be a \$3.00 re-billing charge for each statement sent to you for uncollected amounts due after your insurance has paid. You will be billed a \$30.00 processing fee if your account requires collection or attorney services. We reserve the right to release necessary information to a collection agency or attorney.
- There will be a \$32.00 fee for any returned check.

**Late Cancellation/No Show Policy**

If you are unable to make your scheduled appointment, please cancel at least 24 hours in advance so that another client can be scheduled during that time. If 24 hours notice is not given, you will be charged the full session amount. We are not able to bill your insurance for this amount.

**Confidentiality**

With the exception of certain specific circumstances described below, you have the right to the confidentiality of your therapy. If you would like us to speak with someone about your treatment, we will ask you to sign a "release of information" form before we are able to do so. You may change your mind and revoke this permission at any time. Your health information is also protected under the provisions of the federal Health Insurance Portability and Accountability Act (HIPAA). Please refer to our Notice of Privacy Practices for a complete explanation of how your information is protected. If you elect to communicate with us by email, please be aware that email is not completely confidential. We take precautions to ensure that our computer/ email is protected from being viewed by unauthorized people. However, please be aware that it is possible that your email to us and our email to you could be viewed by third parties, including but not limited to internet service providers, your employer (if using a work computer), and others who have access to your computer and/or email.

Your confidentiality is protected by state law and the rules of our profession except in the following circumstances:

- If you are in imminent danger of seriously harming or killing yourself or another person, we are legally and ethically bound to intervene in any way necessary to prevent that, including contacting family members, the police, and the intended victim, without your permission.
- If we believe that a child or dependent adult has been or is being abused or neglected, we are required to report this to the appropriate authorities.
- If you are involved in a lawsuit, the court may order us to release our records of your treatment.
- If we bill your health insurance for services provided to you, we must submit a mental health diagnosis for you, which will become part of your permanent medical record.

**In Case of Emergency**

If you are experiencing a crisis and are not able to reach us, please call the University of Utah Neuropsychiatric Institute at (801) 583-2500. If you believe that you cannot keep yourself safe, please call 911 or go to the nearest hospital emergency room for assistance.

**Client Consent**

I have read, understand, and agree to the policies of the SLMFTC Service Agreement. I have read and/or received a copy of SLMFTC's Notice of Privacy Practices. I consent to the use of a diagnosis in insurance billing and to the release of any information necessary to complete the billing process. I consent to treatment at Salt Lake Marital and Family Therapy Clinic and understand that I can end therapy at any time. I am at least 18 years old.

Name of Client (please print) \_\_\_\_\_ Signature of Client \_\_\_\_\_ Date \_\_\_\_\_  
Signature of Parent/Guardian (if client is a minor) \_\_\_\_\_ Date \_\_\_\_\_