Alyson Landeros, LMHC, MCAP, CTTP
Licensed Mental Health Counselor
License # 13870

Office Policy and Procedures

Expectations:
Having clear goals, or expectations are useful in a counseling journey as long as individuals, couples or families understand they are the essential variable in us reaching those outcomes. Counseling can open up new levels of awareness that may cause discomfort throughout the counseling journey. Having open and honest communication is an essential expectation of the therapy process.

Length of therapy:
All sessions are 50 minutes in length. An additional 10 minutes is used for payment, scheduling future appointment and/or other business dealings.

Payment for Services:
The fee for services is $100 per 50-minute session. Payments are to be made immediately following each session. Cash, checks and most credit cards are accepted.

Cancellation of Appointments:
On occasion, a situation may arise which prevents you from keeping a scheduled appointment. Please notify me of cancellations at least 24 hours in advance of your appointment. Except in emergency situations, you will be charged your 50 minute session fee for no shows or late cancellations of scheduled appointments.

Confidentiality:
I have been offered the "*Notice of Privacy Policies*." I understand my rights as they have been explained to me in this document. If I have any further questions regarding my Personal Health Information (PHI) or confidentiality within the counseling process I will seek clarification. I have also been given a "*Consent to Release Information*" which gives *Alyson Landeros, LMHC, MCAP, CCTP* the right to release (PHI).

I understand that my patient records are property of *Alyson Landeros, LMHC, MCAP, CCTP* and shall be treated as confidential; that *Alyson Landeros, LMHC, MCAP*, CCTP will conduct routine patient audits to insure quality record maintenance; that my records will not be released without my written consent or as provided by the laws of the state where I am receiving treatment. I understand that if I choose to have my records or treatment updates provided to a third party, I must request this in writing using "*Authorization for Use and Disclosure of Protected Health Information*" form or another acceptable form, with the exception of information I have agreed to release per this acknowledgment.

Consent for Treatment:
I have consented to treatment provided by *Alyson Landeros, LMHC, MCAP, CCTP* I authorize the services deemed necessary or recommended to address my needs.

I acknowledge that Alyson Landeros, LMHC, *MCAP*, CCTP is not a 24/7 treatment care facility and that I am responsible for seeking care at my nearest emergency center or through another provider when Alyson Landeros, LMHC, *MCAP*, *CCTP* is not available.

I have read the above information, and understand that I am encouraged to ask questions, and give input regarding the counseling process at any time. If there is anything in this form that I do not understand, it is my responsibility to seek clarification.

_____

Clients Signature **Date**

_____

Parent/Guardian Signature **Date**

Credit Card Authorization Form

I understand that it is the policy of *Alyson Landeros, LMHC, MCAP, CCTP* that the client or parent/guardian of clients under 18 years of age is responsible for payment at the time services are rendered.

- I understand that payment (cash, check, debit or credit card) for sessions will be conducted the same day, immediately following scheduled counseling sessions.
- I understand that I will be responsible for a payment of $50 for a no show appointment and/or cancellation of a scheduled appointment without giving notice 24 hours prior to appointment time. It is understood that emergencies do occur and will be handled on an individual case by case basis.
- I understand that in cases of bank-refused payment, I understand that my credit card will be charged for the original session fee plus any additional fees incurred as a result.
- If payments are not current, all future sessions will be postponed until the client's account is paid in full.
- I understand that I am responsible to notify *Alyson Landeros, LMHC, MCAP, CCTP* if my credit card information, or payment preference changes.

Credit Card: Visa MasterCard American Express Discover

Name (as it appears on card): _____

Credit Card number: _____

Expiration Date: _____

Security Code: _____

Billing Zip Code: _____

Client/Guardian Name (please print): _____

Client/Guardian Signature: _____ Date:_____