Destin Counseling Services, LLC
3209 W. Smith Valley Road, Suite 224
Greenwood, Indiana 46142
(317) 884-5012 (phone)

Participation Agreement

Appointments: Your progress depends on you keeping regularly scheduled appointments and doing “the work.” We will evaluate the progress of our work periodically to determine the need for further appointments. It is your right to discontinue our work any time you feel it is in your best interest to do so. It is my ethical responsibility to end our work when it is reasonably clear that it is no longer of benefit to you. PLEASE INITIAL _______

Payment: The general fee is $125 for the ***initial evaluation/consultation*** of an individual, and up to $200 for couples and family sessions. An initial evaluation lasts one hour for individuals, and 2 hours (recommended) for couples and families. After the initial evaluation/consultation, sessions will generally last 50-minutes at a cost of $95 per session. Special reports to governmental entities, employers, etc. may become necessary from time to time. The fee for such reports is $25. PLEASE INITIAL _______

Cancellations: If you find it necessary to cancel a scheduled appointment, 24 hours notice is required. With less than 24 hours advanced notice, you will be responsible at the following rates:

- First time - 50% of the total regular fee
- Second time – 100% of the total regular fee
- Failure to show for an appointment will result in a full charge for the session

Please note that this is an out of pocket expense, as Destin is self-pay. PLEASE INITIAL _______

Insurance: Destin clients are self-pay. This office does not submit claims. Upon request, a detailed receipt can be provided which you can submit to your insurance company for any reimbursable expenses.

Destin may be considered an “out-of-network” provider. The decision to hold an “out-of-network” designation is rooted in the belief that we can work together, without restrictions that insurance companies/managed care can sometimes impose. This allows us to create the most thorough action plan for you and your family. Please check with your insurance company to determine if you can submit your expenses for reimbursement. PLEASE INITIAL _______

Confidentiality: What you say in session, your records and attendance are confidential, except:

1. When you give written permission to release information;

2. When your records are subpoenaed for legal reasons;

3. When reporting is required or allowed by law (suspected child abuse or neglect, extreme danger to self or others, suspected elder abuse, etc.); other exceptions as listed in my **HIPPA Notice of Privacy Practices**.

4. If information is requested from a third party (e.g., family member, schools, courts, or other mental professionals, etc.), it would be helpful to discuss this with me as soon as possible. At some point, I may be engaged in supervision with a senior, professional Marriage and Family Therapist, an overview of your particular situation may be explored. During any supervisory meetings, the details regarding you, your family, your place of work, etc. will not be divulged. PLEASE INITIAL _______

Electronic Communication: Ethical conviction lends itself to the restriction of email and faxed correspondence. In instances where these devices are used, they will generally be used for the exchange of information and not for the purposes of rendering therapy or therapeutic feedback. PLEASE INITIAL _______

Emergencies: Please note that Destin is a small counseling practice. Therefore, in the case of an emergency, please proceed to a safe place that could include the nearest hospital or emergency room. PLEASE INITIAL _______

Consent: It is understood that by signing below, you consent to participate in counseling provided by Destin Counseling Services. You further understand that you are consenting and agreeing only to those services provided by Destin, and that there are other therapists in the suite that operate independent practices and are not responsible for your care. You also understand that I am not responsible for the care provided by professionals or groups that I may refer you to as may become necessary.

By signing below, you acknowledge receipt of my HIPAA Notice of Privacy Policies. This Notice provides information about how I may use/disclose your private health information. I encourage you to read it carefully. My Notice is subject to change; if changed, I will give you a revised Notice.

______________________________ ________________________________ ______________
Client Signature Client Printed Name Date

______________________________ ________________________________ ______________
Second Client Signature Second Client Printed Name Date

______________________________ ________________________________ ______________
Parent/Guardian Signature Parent/Guardian Printed Name Date

______________________________ ________________________________ ______________
Service Provider Signature Service Provider Printed Name Date