Atlantic Counseling & Consultation
Phone: (781) 335-6000 49 Pleasant Street Weymouth, MA 02190 Fax: (781) 340-5358
www.atlantic-counseling.com

SELF PAY
PATIENT AGREEMENT

INTRODUCTION: Welcome to Atlantic Counseling and Consultation, Inc. Our practice is designed to provide you with the highest quality care at a reasonable fee. We are individually licensed, by the state, as independent practitioners. Each therapist has at least 10 years experience providing individual, group, family or couples therapy as well consultation to schools and agencies.

FEES AND PAYMENT:

Cost depends on services being provided. Please speak with your clinician for more information. Payment is due at the time of the visit.

If we are asked to attend meetings, appear at court, consult with schools, or complete requested paperwork that is deemed clinically appropriate, the fee will be our hourly rate plus preparation and travel.

MEDICAL: We suggest that you get a full physical before beginning treatment, to rule out any medical problems.

CONFIDENTIALITY: Our counseling practice is a professional one. We are bound by our own personal and professional ethics to hold everything you say in strict confidence. There are four (4) exceptions to this rule:

1.) If I have your permission to consult with other professionals, such as doctors, teachers or previous therapists.
2.) If I am subpoenaed to court to testify about you.
3.) If, in my clinical opinion, you are in danger of hurting yourself or others.
4.) If you allege sexual or physical abuse. All licensed clinicians are mandated by the state to report abuse.

Please review our Notice of Privacy Practices for Protected Health Information.

These exceptions, especially the second and third, are extreme situations that happen infrequently. We do feel, however, from the onset it is important for you to know our legal and moral obligations, as well as our conviction, that we will respect and uphold your privacy.

TIME: We expect to begin and end on time for each session. Should you be delayed, we will still have to end on time. Should we be delayed, you will be provided the full session.

CANCELLATION & NO SHOW POLICY:

Please schedule your sessions at a time that you will be available. In order for treatment to be of most help to you, it is essential that you prioritize your commitment to attend all scheduled sessions. If there is a need to cancel and we are notified at least 24 hours in advance, there will be no charge for the appointment. **There is a fee of $90.00 for any appointments you fail to keep if we have not been notified at least 24 hours in advance.** We highly encourage you to plan accordingly to avoid any charges.

Patient's initials: _____

OUR AGREEMENT: My job is to help you achieve your goals within the parameters of this contract. By signing our names below, we have agreed to comply with all the points. We agree to work together until our goals are reached or until we decide, together, to discontinue.

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YOUR GOALS: (Please fill in)

1. _____
2. _____
2. _____

Signature of Patient: _____

Signature of Parent or Guardian (if applicable): _____

Signature of Provider: _____

Date: _____