

Susan Cummings Nicholson, PhD, LCSW, BCD

Adult and Couples Teletherapy drsusancummingsnicholson.com

Phone: 757-873-3401 Email: scn@drsusancn.com Fax: 757-223-1165

Mailing address: 25 Hidenwood Shopping Center #6364, Newport News, VA 23606

Practice address: 739 Thimble Shoals Blvd. Suite 704-7, Newport News, VA 23606

TREATMENT AGREEMENT

Please initial in each box on the left after reading the text to the right and please sign on page 2:

Initial Below	
	FEE FOR SERVICE: The basic fee per 53-minute session is \$165. This amount is due at the end of our session unless you have requested that I bill your health insurance. If you are using health insurance, only your copayment or coinsurance is due at the end of each session. If you are using insurance, your insurance plan determines the portion of my basic fee that I actually receive for services rendered (allowable amount). Your insurance plan also designates the portion of the allowable amount, that becomes your copay or coinsurance.
	FEE FOR MISSED APPOINTMENTS (NO SHOW, LATE ARRIVAL OR LATE CANCELLATION): Sessions are by appointment only. I make appointments and receive cancellations through the cell/text number provided when your initial appointment is confirmed. Once you make an appointment, I reserve and hold that time for you until you cancel it, thereby making it unavailable for any other client who needs services. I require at least a 24-hour notice for cancellation of an appointment (except for medical emergency). Appointments that are missed or cancelled without the 24-hour notice are considered Missed Appointments. A late arrival of more than 8 minutes is considered a Missed Appointment, and you will need to reschedule for another time. The Missed Appointment Fee is \$65. This fee cannot be billed to your insurance. Payment is due on the day the appointment is missed.
	INSURANCE: I am happy to submit claims to your insurance company for your session fees. Your copay or coinsurance is due at the time of service. If you are still in a deductible period in your insurance plan, you are responsible for payment of the allowable amount of the sessions, as set by your plan, until your deductible is satisfied. If your insurance refuses to pay the expected amount for your plan, you are responsible for the unpaid amount. You have the right to waive using insurance coverage, if desired.
	SECONDARY INSURANCE: I am happy to also submit claims to your secondary insurance. It is your responsibility to tell me about all insurance plans that will cover your sessions (including coverage under a family member's policy, as well as your own). If claims are denied by the only insurance plan information you provided, then you may have to pay for services out of pocket and then use an invoice from me, to request from your insurance plan, reimbursement for your payment.
	DIAGNOSIS: When you use health insurance to cover your services, I am required to provide to your insurance plan(s) a clinical diagnosis that reflects your symptoms and presenting problems.
	LIMITS OF MEDICAL COVERAGE: Even if you have insurance coverage for unlimited sessions, some health plans occasionally review treatment notes for medical necessity, and sometimes limit the length of treatment or frequency of sessions. Even though my office checks coverage under your plan, you are ultimately responsible for verifying and understanding the limits of your coverage, and for paying for any charges that your insurance does not pay. Please review your Explanation of Benefits statements for each visit, so you can contact your benefits office promptly, if something is unclear.
	CONFIDENTIALITY: What you say in therapy, your records, and your attendance are all confidential information. Exceptions would include a court-ordered subpoena, your written permission to release information, or when reporting is required or allowed by law (ex. suspected child abuse or neglect, extreme danger to self, elder abuse, or danger to others). Find more information in my <i>Notice of Privacy Practices</i> .
	IN EMERGENCY: If you ever believe that you are a danger to yourself or someone else, call 911 or go immediately to the nearest hospital emergency department for assistance. In addition, if you believe you are in an emergency situation, you may also contact me directly through the text/cell number that I provide

	to you when our initial appointment is confirmed. This is the most direct way to contact me. If I were ever unavailable to receive a call from my clients, my phone greeting would provide contact information for another therapist, who can be called in an emergency.
	EMAIL: Please do not use email for appointment changes; use the text number provided. I discourage clients from emailing private information to me between sessions, because of possible confidentiality risks through that technology. Be sure to jot down important information, to discuss in our next session.
	SOCIAL MEDIA: I do not accept friend requests or contact requests from clients on social networking sites, because of the requirement that I keep professional and personal contacts separate.
	REFERRALS: If ever you and/or I believe that you could be better served by a therapist with a different expertise or style than mine, I would provide you with referrals to other therapists. I cannot be responsible for the care received from professionals to whom I may refer a client.
	END OF THERAPY: If you decide you are ready to end your course of treatment, and if we have not already been discussing the timing for this, I strongly encourage you to discuss with me your wishes, so we may review together your progress and goals achieved before you stop therapy. Also, it is my ethical duty to provide therapy only when I believe the client is actively participating and benefiting from the sessions. If ever there is a client history of repeated missed appointments or other treatment interruptions that seem to indicate a lack of investment in therapy, I may decide that ending treatment is the best option.
	PATIENT RIGHTS: You have the right to ask questions about your treatment or refuse to participate in treatment. This office does not discriminate in the delivery of healthcare services based on race, ethnicity, national origin, citizenship or immigration status, religion, gender, gender identity, age, mental or physical disability, sexual orientation, medical history, or source of payment.
	PRIVACY PRACTICES: By initialing here and signing below, you are acknowledging that a downloadable copy of my <i>Notice of Privacy Practices</i> has been made available to you through my website (or by USPS if requested). My <i>Notice of Privacy Practices</i> provides information about how I may use and disclose your private health information. It also gives you information on how to make a complaint, if you are dissatisfied with the services that I provide you.

PLEASE SIGN HERE IF YOU ARE USING HEALTH INSURANCE:

(1) "I authorize the release of any information necessary (including dates of service, notes, treatment summaries and diagnoses) to process insurance claims, to provide medical necessity for treatment, to request additional sessions, or to comply with insurance plan requirements for treatment reviews or mandated administrative chart reviews."

Signature: _____ **Printed Name:** _____ **Date:** _____

Signature: _____ **Printed Name:** _____ **Date:** _____
(of second participant in conjoint session, if applicable)

(2) "I authorize payment of benefits to Dr. Susan C. Nicholson, Thimble Shoals Counseling & Therapy."

Signature: _____ **Date:** _____

PLEASE SIGN HERE TO ACKNOWLEDGE UNDERSTANDING OF THE ENTIRE TREATMENT AGREEMENT:

"By signing below, I acknowledge that I have read and that I understand the above policies.

Signature: _____ **Printed Name:** _____ **Date:** _____

Signature: _____ **Printed Name:** _____ **Date:** _____
(of second participant in conjoint session, if applicable)