John Cutrone, LMHC, LLC
2000 Banks Rd., Ste. 217, Margate, FL 33063
Phone: (561) 289-9722 Fax: (561) 544-7149 Website: www.CutroneLMHC.com

Consent for Treatment

Welcome to John Cutrone, LMHC, LLC. This document contains information about the professional services and policies which are an integral part of our work together. Please read this document carefully, and feel free to discuss any questions you may have.

Sessions – Sessions are typically 50-60 minutes long and are generally scheduled on a weekly basis, unless otherwise agreed-upon. Coming to scheduled sessions consistently and on time will allow you to maximize your time and work toward reaching your goals.

Fees – My standard rate for a standard 50-60 minute session is **$200 per session**, **unless otherwise agreed upon.** For clients who wish to use their insurance coverage for plans that I am paneled with, clients will be responsible for all copays, co-insurances, deductibles, and any fees for services that are not covered or are denied by insurance.

I accept payments in the form of cash, credit card, or check. The Client assumes any and all responsibility for paying **John Cutrone, LMHC, LLC,** the fee of $35 per returned or "bounced" check. **The agreed-upon fee per session can be found on Page 2.**

Cancellations – Your session time is reserved specifically for you. You agree to contact me with more than 24 hours notice if you need to cancel or reschedule. **You will be responsible for the full fee (or my contracted rate if using insurance) if you no-show or do not reschedule/cancel with at least 24 hours notice. Arriving more than 15 minutes late could result in session being rescheduled and the late-cancel fee charged. Any outstanding balances must be paid prior to the next scheduled session.**

Contacting Me – You may leave confidential phone messages at any time. It helps if you leave a few specific times when I can reach you. I will do my best to return your call on the same day, or on the next business day. Texts or emails are not guaranteed to be confidential. Other than phone calls to schedule and confirm appointments, any phone consultations longer than 10 minutes will be charged in 15-minute increments, at one-quarter of your agreed-upon rate for a 50-minute therapy session. **If I will be unavailable for an extended time, I will provide you with the name of a colleague for you to contact if necessary.** This colleague is bound by the same legal, ethical, and privacy guidelines as I am.

Emergency Procedures – I **Do Not** provide on-call Crisis/Emergency Mental Health care. **Therefore, in the event of a life-threatening emergency, or immediate physical or medical crisis, you agree to contact 9-1-1 or go to the nearest emergency room or hospital.**

Confidentiality - Your privacy is extremely important to me. Information disclosed to me is generally protected by laws and ethics. I need your permission before I may release any information concerning your treatment, except under the following circumstances: 1) if there is a reasonable suspicion of abuse/neglect of a child, elderly, dependent, or disabled person; 2) if you may be in danger of harming yourself or another person; 3) as required by a third-party to obtain reimbursement; and 4) as otherwise ordered or required by law (for example as a result of a court order). This form does not cover every possible exception. **Please refer to the HIPAA Notice of Privacy Practices, which I supplied you.**

Professional Development – There may be situations where I may share some information about our work together. I may discuss aspect of treatment in consultation with other therapists. I may also share aspects of my work in teaching, presentations, or publications. In either case I will make sure to protect personal identities, and will not use identifying information or disclose confidential information about you.

Records – I keep confidential records and personal information of our sessions. However, if you are using insurance or the employee assistance program for payment, they may be able to access, request, or audit your records for payment and authorization purposes.

Additional Charges – Additional charges may be assessed for services other than therapy sessions. Additional charges may be discussed with **John Cutrone, LMHC, A-CAS, in advance** for such things as: requests for specific letters, copies of records, disability paperwork, litigation, collateral contacts, or other situations not listed here.

Conclusion of Therapy – Termination of therapy is an important aspect of the therapeutic process and is best when it is a collaborative effort. While services are voluntary, It may be best to schedule a final session to discuss and plan for the end of services with me, as well as possibly process any underlying reasons (i.e. goals are met, other needs, etc.).

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(The blank spaces below indicating the fees for the first and additional sessions will be determined in our telephone call scheduling your appointment. Fees are determined by the services to be provided.)

The fee/copay for my first session will be $_____. Additional sessions will be at a rate of $_____.

INITIAL HERE_____ *Additional fees may be assessed for services provided other than scheduled therapy sessions, including, but not limited to: missed visits, phone consultations over 10 minutes, reports or letters composed at the client's request or authorization, copies of records, or involvement in litigation. Examples of some additional fees are listed below. Please understand that advanced notice may be required to fulfill some requests.*

- Missed visits/cancellations w/ under 24-hours notice, will be billed the full fee (or insurance contracted rate) for each missed visit when applicable, due in full prior to the next scheduled session/visit/service.
- Phone consultations over 10 minutes in length will be billed in 15-minute increments, with each 15 minutes being billed at one-quarter of your agreed-upon/contracted hourly session rate.
- Letters or reports written at your request will be billed to you at your agreed-upon/contracted hourly session rate x the length of time required to complete this documentation.
- While I don't testify in court, any Court Appearances will be $200 per hour x the number of hours required, plus travel expenses, at a minimum of a 4-hour block of time, and hourly thereafter, due in full prior to court.
- Copies of records will be billed at $1.00 per page, plus any postage costs.

I give my consent to receive therapeutic services provided by John Cutrone, LMHC, A-CAS. The undersigned understands that John Cutrone, LMHC, A-CAS, is a Licensed Mental Health Counselor in the State of Florida. The undersigned has asked John Cutrone, LMHC, A-CAS, any pertinent questions prior to initiating treatment and is voluntarily seeking his services. I understand that therapy with John Cutrone, LMHC, A-CAS, can be terminated at any time. I understand that, should I cease attending sessions with John Cutrone, LMHC, A-CAS for thirty (30) days without prior notification/discussion, or no-show, late-cancel or reschedule (under 24 hours) for 2 consecutive or 3 total sessions, my case may be closed. If my case is closed, I may discuss the possibility of resuming therapy with John Cutrone, LMHC, A-CAS, by contacting him at (561) 289-9722.

I also understand that John Cutrone, LMHC, A-CAS, is not a medical physician, psychiatrist, attorney, or psychologist. Thus, he will not provide advice on medical, psychiatric, or legal matters, other than by means of referral. I understand that John Cutrone, LMHC, A-CAS, is not responsible in any way for the actions of any professionals to whom referrals might be made.

_____ _____
Signature of Client (or Legal Guardian if client under 18) Date

_____
Printed Name of Client (or Legal Guardian of client)
(If Legal guardian, indicate relationship to client)

_____ _____
Signature of Other Participant Date

_____
Printed Name of Other Participant (and relation to client)

_____ _____
Signature of Therapist (John Cutrone, LMHC, A-CAS) Date

John Cutrone, LMHC, A-CAS
Printed Name of Therapist