THE MARIPOSA CENTER LLC
FOR INFANT, CHILD & FAMILY ENRICHMENT

Policies and Procedures Agreement

This Agreement is made and entered into by and between _____(therapist), who is a sole proprietor at The Mariposa Center, and the Client. This Agreement shall be read in conjunction with The Mariposa Center's Informed Consent and Disclosure Statement and is incorporated by reference into this Agreement.

Financial Policies

- If you are a client not utilizing insurance or other payment programs, the fees for a 50-minute individual, family or couple psychotherapy session at The Mariposa Center are:
  $125.00 per 50 min. for a Licensed Professional Counselor or Licensed Clinical Social Worker
  $85.00 per 50 min. for a Licensed Professional Counselor Candidate
  $10.00 per 50 min. for an Intern or $40.00 per 50 min. for an Extern
- Your therapist at The Mariposa Center is in-network with several different insurance companies and Medicaid BHOs, so please ask us about your insurance situation. We are able to provide statements for out-of-network insurance reimbursements. We also work with several Early Interventions Programs and Victim's Compensation Programs.
  - By signing this Agreement, you understand that you are legally responsible for payment for your therapy services. If for any reason, your insurance company, HMO, third-party payor, etc. does not compensate your therapist, you understand that you remain solely responsible for payment.You also understand that signing this form gives permission to your therapist to communicate with your insurance company, HMO, third-party payor, collections agency, or anyone connected to your funding source regarding payment.You understand that your insurance company may request information from your therapist about the therapy services you received, which may include, but is not limited to: a diagnosis or service code, description of services or symptoms, treatment plans/summary, and in some cases your entire client file. You understand that once your insurance company receives the information you or your therapist has no control of the security measures the insurance company takes or whether the insurance company shares the required information. You understand that you may request from your therapist a copy of any report s/he submits to your insurance company on your behalf. Failure to pay will be a cause for termination of therapy services. _____(Initial)
- Each therapist has limited spaces available for reduced fee clients. Please talk to your therapist to check this availability.
- Based upon this payment information, your fee will be: _____. If your financial situation changes, please inform your therapist_____(Initial).
- **Payments are due** at the beginning of the session via cash, check, or credit card and will go directly to your individual therapist. If paying with cash or check, your fee will be discounted $5.00 from the regular fee. Please be aware that fees and policies are subject to change every 6 months. You will be notified 30 days prior to any change in fees. All accounts that are not paid within 30 days from the date of service for self-pay clients, shall be considered past due. If your account is past due, please be advised that your therapist at The Mariposa Center may be obligated to turn your account over to a collection agency or seek collection with a civil court action. By signing below, you agree that your therapist at The Mariposa Center may seek payment for your unpaid bills with the assistance of a collections agency. Should this occur, your therapist at The Mariposa Center will provide the collection agency or court with your name, address, phone number, and any other directory information, including

dates of service or any other information requested by the collection agency or court deemed necessary to collect the past due account. Your therapist at The Mariposa Center will not disclose more information than necessary to collect the past due account. Your therapist at The Mariposa Center will notify you of its intention to turn your account over to a collection agency or the court by sending such notice to your last known address._____(Initial).

- **All billing is done through:**
  Jessica Dennis
  Colorado Medical Billing, LLC
  PH: (720) 898-8711; F: (720) 897-2833; comedbill@gmail.com
  Please ask to see a copy of our biller's privacy policy.
- **No-show and Cancellation Policy**: Your visit has been reserved especially for you. 24-hour notice is required in order to cancel your appointment with no charge, excluding emergencies. If you do not call to cancel or reschedule your appointment, it is considered a "no-show." The fee for the first no-show is waived. You will be charged the full rate for all subsequent no-shows_____(Initial). If your insurance company does not cover this cost (and most insurance companies do not), you will be required to self-pay for the missed appointment. Please complete the **Credit/Debit Card Information Form** – this information can be utilized for your regular payment and/or in the case of a no-show. In the event of sudden illness or an emergency, please contact your therapist to determine if an exception can be made to this policy.
- **Additional charges will be made for the following services provided at the rates listed:**
  Attending meetings, report writing, and client-requested consultation with other professionals will be charged at the normal hourly rate, but will be prorated to the nearest quarter hour. _____(Initial) Out of session e-mails and phone calls lasting longer than 15 minutes will be charged the normal hourly rate and tallied in 15-minute increments. ____ (Initial)
  Court and/or legal-related matters on your behalf are charged at a higher rate of $300.00 per hour. This includes, but is not limited to: attorney fees your therapist may incur in preparing for the requested legal services, case research and preparation, report writing, travel, depositions, actual testimony, cross examination time, and courtroom waiting time._____(Initial)

Additional Policies

- **Therapy is a unique journey** for you/your child that can lead to health and healing. There is no guarantee that psychotherapy will yield positive or intended results. Although every effort will be made to provide a positive and healing experience, every therapeutic experience is unique and varies from person to person. Results achieved in a therapeutic relationship with one person are not a guarantee of similar results with all clients. Therapy is a collaborative effort and requires commitment from you/your child. The therapist's role in your/your child's journey is not to "fix" but to facilitate your/your child's journey towards health. This requires that you communicate in a respectful manner towards your/your child's therapist, that you remain on the premises during your child's session, that you/your child will not come to therapy under the influence of any substances, and that you/your child will maintain a commitment to therapy "homework" agreed upon with your therapist. ____(Initial)
- **If you are receiving family therapy**, please know that, "the family is the client," and that our therapists maintain a strict "no secrets" policy. This means that information revealed to the therapist by one family member must be revealed to all family members, as it is neither therapeutically beneficial nor ethically correct for family members to be kept unaware of family secrets. The therapist will guide the family if this situation occurs and will model good communication skills. Please see your therapist's disclosure statement for more information. _____(Initial)
- **If your family is in the process of a divorce**, please keep in mind that both parents have the right to information pertaining to their child/children, unless a court determines otherwise. All parents are asked to sign a communication agreement which allows (but does not require) the therapist to communicate with both parents and share any communications between one parent and the therapist with the other parent. If you are consenting to treatment and therapy services for your minor child/ren, you must produce the Court Order Custody Agreement and/or Parenting Plan that grants you the authority to consent to mental health services for your minor child/ren. Further, you understand and agree to keep your therapist informed of any proceedings or supplemental court orders that affect your parenting rights, custody arrangements, and decision-making authority. You understand

that failing to provide the Court Order Custody Agreement and/or Parenting Plan will prohibit your therapist from providing therapy to your minor child/ren. Please keep in mind that it is outside the guidelines and beyond the scope of ethical practice for a therapist to give opinions about custody and parenting time. Any request for custody recommendations will be denied. The court is able to appoint professionals with the expertise to make such recommendations. Therapists at The Mariposa Center do not provide reports to Child and Family Investigators. _____(Initial)

- **When more than one person is responsible for payment,** all parties' credit cards must be on file. If there is nonpayment for 2 sessions by any party, treatment will stop until payment disputes are resolved. The therapists at The Mariposa Center will not be responsible for resolving payment disputes; this must be worked out amongst the paying parties. Please be aware that your appointment time may not be reserved for you during this time. _____(Initial)
- **Clients who indicate self-harming, suicidal, or homicidal thoughts or behaviors** will be asked to sign a safety plan outlining a specific plan of action to be followed during the course of therapy._____(Initial)
- **Choosing a "best fit" therapist is the client's right** and if during a time where one therapist is covering for another (i.e., maternity leave, vacation, illness) you identify the covering therapist to be a better match for you/your child, we respectfully ask that you follow this transition process:
    1. Attend two (2) termination sessions with your/your child's initial therapist.
    2. Attend an initial consultation session with your/your child's new therapist, realizing that you may be put on a waitlist until the new therapist has a regular opening. _____(Initial)
- **Non-emergency Services.** Therapist self-care is vital to ensure the highest quality of care is provided to our clients. It is important that you be aware that therapists will not answer emails or phone calls after hours or on the weekends. We are an outpatient practice and therefore do not provide emergency psychotherapeutic services or transportation to/from the hospital. The therapists at The Mariposa Center provide non-emergency services during stated business hours and by scheduled appointment only. Therapists will return calls during stated business hours only. If you must seek after hours treatment from any counseling agency or center, emergency room, or hospital, you understand that you remain solely responsible for any fees that arise from that care. _____(Initial)
- **Discontinuing Therapy.** You understand that should you choose to discontinue therapy for more than 60 days by not communicating with your therapist at The Mariposa Center, your treatment will be considered terminated. You may be able to resume therapy after the 60 day period by discussing your decision to resume therapy services with your therapist. Ability to resume therapy after 60 days will depend upon your therapist's availability and will be within his/her sole discretion. Your Disclosure Statement/Informed Consent for Treatment and these Policies will remain in effect should you resume therapy if one (1) year has not elapsed since your last session. However, you may be asked to provide additional information to update your client record. You understand that "discontinuing therapy" means that you have not had a session with your therapist for at least 60 days, unless otherwise agreed to in writing._____(Initial)
- **Social Media.** You understand that your therapist does not accept personal Facebook, LinkedIn, Twitter, Instagram, and/or other friend/connection/follow requests via any social media. Any such request will be denied in order to maintain professional boundaries. Your understand that The Mariposa Center has, or may have, a business social media account page. You understand that there is no requirement that you "like" or "follow" this page. You understand that should you "like" or choose to "follow" The Mariposa Center's business social media page that others will see your name associated with "liking" or "following" that page. You understand that this applies to any comments that you post of The Mariposa Center's page/wall, as well. You understand that any comments you post regarding therapeutic work between you and your therapist will be deleted as soon as possible. You agree to refrain from discussing, commenting, and/or asking therapeutic questions via any social media platform. You agree that you will contact your therapist with any therapeutic comments and/or questions through the mode you have consented to and not through social media. If you have any questions regarding social media, review websites, or search engines in connection to your therapeutic relationship, you agree to immediately contact your therapist and address those questions._____(Initial)
- **Teletherapy and Technology.** In general, The Mariposa Center and its therapists do not provide Teletherapy, such as therapy over the phone or video chat. You understand that communications via email and text should be limited to administrative purposes (like scheduling or notification of delayed arrival), and not used as an avenue

for therapy. You agree to discuss any request you make for Teletherapy with your therapist. You understand that it is in your therapist's sole discretion whether to accommodate your request for Teletherapy. _____(Initial).

- **Communication by Unsecure Transmissions.** By signing this Agreement you allow The Mariposa Center to contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Any information that is not provided in-person shall be provided in accordance with The Mariposa Center's form: Consent for Communication of Protected Health Information By Unsecure Transmissions. You understand that if you initiate communication via electronic means that you have not specifically consented to in the Consent for Communication of Protected Health Information By Unsecure Transmissions form, you will need to amend the consent form so that your therapist may communicate with you via that method._____(Initial)
- **I acknowledge** that in addition to this form, I have seen, been offered a copy of, and agree with the terms of both the Informed Consent for Treatment/Disclosure Statement and the Notice of Privacy Practices._____(Initial)
- **I understand that this version** of The Mariposa Center's policies goes into effect June 23, 2016 and replaces all former policy documents. _____(Initial)

Client('s) Name(s):_____

Client or Parent/Guardian Signature: _____Date:_____

Therapist Signature: _____Date:_____