THE MARIPOSA CENTER LLC
FOR INFANT, CHILD & FAMILY ENRICHMENT

Financial Policies

- If you are a client not accessing insurance or other payment programs, the fees for The Mariposa Center for a 60-minute individual, family or couple psychotherapy session are:
  $100.00 per hour for a Licensed Professional Counselor
  $80.00 per hour for a Registered Psychotherapist or Licensed Professional Counselor Candidate
  $10.00 per hour for an Intern or Extern

- Private pay clients are also entitled to an initial "meet and greet" session at no charge.

- The Mariposa Center is in-network with several different insurance companies, 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.

- Each therapist has limited spaces available for sliding fee scale 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.

- **Payments are due** at the beginning of the session via cash, check or credit card. If paying by credit card, a $3.00 service charge will be added to your regular session fee. Please be aware that fees and policies are subject to change every 6 months. If The Mariposa Center has an ongoing or significant problem collecting fees from you, we reserve the right to utilize the services of a collection agency. The Mariposa Center will only disclose relevant information about you (i.e., name, contact information) if this circumstance arises_____(Initial).

- **All billing is done through:**
  Jessica Dennis @ Colorado Medical Billing, LLC
  5738 Olde Wadsworth Blvd. Arvada, CO 80002. 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. 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, 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. _____(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 testimony on your behalf is charged at a higher rate of $300.00 per hour. This includes related matters like case research and preparation, report writing, travel, depositions, actual testimony and 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. It is a collaborative effort and requires commitment from you/your child's parent. 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, 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 reveled to the therapist by one family member must be revealed to all family members, as it is neither therapeutically beneficial nor ethical 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. _____(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. Should custody and decision-making be rewarded solely to one parent that particular parent has sole rights to information. Please keep in mind that it is outside the guidelines of ethical practice for a therapist to give opinions about custody and parenting time. _____(Initial)

- **Clients who indicate self-harming, suicidal, or homicidal thoughts or behaviors** will be asked to sign a safety contract outlining a specific plan of action to be followed during the course of therapy. _____(Initial)

- **For my safety and the safety of my children**, I agree not to attend counseling /classes at The Mariposa Center while I am under the influence of any controlled substance. I understand that if I do arrive at the Mariposa Center intoxicated, my session will be cancelled and my therapist may have to contact authorities, including but not limited to the police and child protective services. I also understand that my therapist is able connect me to additional resources that can help me, if need be. _____(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)

- **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 texts, e-mails 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. _____(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 To Treatment and the Notice of Privacy Practices._____(Initial)

Client(s) Name(s):_____
Client or Parent/Guardian Signature:_____ Date:_____
Therapist Signature:_____ Date:_____