Jonathan League, LPCC-S, LICDC (E.0004364-SUPV)
6400 Thornberry Ct, Suite 620, Mason, OH 45040
Ph: (513) 229-8386 • Fx: (513) 229-8385

Thank you for contacting my office. Below is some important information that will help us work effectively and respectfully together.

APPOINTMENTS:
Appointments usually last 50 minutes. Your appointment is reserved for you and it is rarely possible to reschedule that appointment time without a 24-hour notice. Therefore, you will be charged the full session fee for appointments not canceled within 24 hours.

EMERGENCIES:
If you have an emergency, leave a message marked urgent and where you can be contacted at (513) 299-8386; your call will be returned within 24 hours. Under circumstances where you believe it is not possible to wait, please contact 911 or other go to the nearest hospital emergency department.

FEES:
The fee structure is as follows:

Initial Consultation	$175	
Psychotherapy Session (50 min)	$150	
Family / Couples Session (90 min)	$175	
Billable professional time	$95	*includes but is not limited to: phone calls, records retrieval and sending, treatment summaries, test scoring & interpretation, reports, or letters on your behalf. (Per hour)

FORENSIC ASSESSEMENTS, COURT APPEARANCES, ETC.:
It should be understood that legal and ethical standards may prohibit the utilization of your therapist as a forensic/expert witness (e.g., in child custody cases) in keeping with ORC 4757-6-01. Additional fees are applicable in the event of your therapist being called to testify. Billable hours for court appearance, preparation, and travel time shall be $150 per hour. The client shall reimburse all expenses for travel, consultation, record preparation, and appropriate professional expenses.

INSURANCE:
Most insurance, HMO's and managed care companies partially cover fees for psychological diagnosis and treatment. It is your responsibility to be familiar with your insurance coverage and your portion of fees or co-payments. If your insurance/managed care company requires a referral or preauthorization for services, and you are here without one, or if you are seeking services from an out-of-network provider, you insurance/managed care company may deny benefit payments. In that case, you will be financially responsible for these services. Please read your subscriber's manual and call your company if you have questions.

BILLING:

Your insurance co-payment is due at the time of service. If payment is not received from your insurance company within 60 days of filing the claim, you will be responsible for the bill. Please note that a collection agency is used for any bills of 120 days past due. The collection fee is charged directly to the patient's delinquent account.

CONFIDENTIALITY:

Your signature below allows me to offer treatment to you or your dependent and also indicates that you have read the confidentially statements provided to you. It is important for you to know that in general, our discussions and your charge are private and protected by law. I do not tell anyone what we discuss unless you request, in writing, that I do so with a specific person or specific purpose. There are a few exceptions to this privilege:

1. I am required by law to tell others when I suspect there is imminent danger to yourself or others.
2. I must also report child/elder abuse if I see evidence of such abuse.
3. I must disclose certain confidential information to insurance companies when applying for treatment authorization or insurance reimbursement.
4. If a court of law subpoenas your records, I may be required to provide the information specified.
5. Your counselor's practice is within Adult, Child, Family Counseling of Mason and she/he may consult with other ACF staff. At times, they may need to share protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing, emergency absences, and quality assurance. All of the mental health professionals are bound by the same rules of confidentiality. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without legal authorization.
6. Parents have a right to know about treatment of minor children.
7. Personal information about you will be sent to a collection agency in the unlikely event that your bills are not paid within 180 days.

ELECTRONIC SERVICE DELIVERY (INTERNET, EMAIL, ETC.):

Please note that non-encrypted Internet e-mail communications, may be accessed and viewed by other Internet users, without your knowledge and permission, while in transit to me. You should also know that the e-mail from me does not provide a completely secure and confidential means of communication. *For that reason, to protect your privacy, please do not use e-mail to communicate information to me that you consider confidential.* While I strive to protect your personal information, I cannot ensure or warrant the security of any information you transmit to me or receive from me.

DIAGNOSIS OF MENTAL AND EMOTIONAL DISORDERS:

I am licensed as a mental health professional to make a diagnosis of mental and emotional disorder(s) in accordance with the Diagnostic and Statistical Manual 5. In the event that insurance billing occurs, information regarding that diagnosis will be released to the insurance and will become part of the client's medical record. Should the client have questions about the implications of such a release it is important that he or she voice those concerns with the therapist.

CONTRACT:
I HEREBY AUTHORIZE Jonathan League, LPCC-S, LICDC-S, to render treatment and/or assessment to me, my dependent, or person for whom I serve as legal guardian. I have read the proceeding policies and information sheet. I understand the right of confidentiality is not absolute. I assume personal financial responsibility for all treatment and assessments conducted by Jonathan League per the terms of this contract. Such responsibility is not transferable to any other person even in the case of custody or child support disputes and/or related court decrees.

_____ _____
Client/Parent/Legal Guardian Signature Date

_____ _____
Counselor Signature Date

NOTICE OF PRIVACY PRACTICES:
I HEREBY ACKNOWLEDGE that I was informed of, and given a copy of the Notice of Privacy Practices for Jonathan League, LPCC-S, LICDC-S to read.

I was also given the opportunity for a paper copy to keep if so desired.

_____
Printed Name of Client/Parent/Guardian

_____ _____
Client/Parent/Guardian Signature Date