LORI KIMMERLY TH

Exploring The Sacred Space Of W

Service Agreement

Lori KimmerlyTherapy and Coaching, PLLC provides professional therapy for individuals, couples and families. Please read this Service Agreement carefully so you will understand our policies and procedures.

Fees

Fees for the first diagnostic assessment appointment are $160.00. Fees for subsequent appointments range from $60-125. Sliding scale fees range from $60-80 per session and are available and negotiated based on financial need by each therapist at Lori Kimmerly Therapy. Please ask for further details about sliding scale with your individual therapist. By signing this agreement, you agree to pay for all services at this rate for all non-insurance covered services provided to you. We reserve the right to change our fees.

Payments

Payment is due at the time of service. However, there may be circumstance including insurance billings that may modify that timing. Please discuss any questions you have about this with us, and a reasonable payment schedule will be determined. We will also discuss and determine the method of payment. If a check is returned because of insufficient funds, you will be charged the actual cost for handling.

Appointments

Appointments are scheduled via the client portal at www.lorikimmerlytherapy.com and can be made up to 120 days in advance. Once established, your appointment is reserved just for you. Any missed or cancelled appointment with less than 24 hours notice will be charged at $50.00. If two appointments in a row are missed or cancelled with less than 24 hours notice in a row, your regularly scheduled appointment will removed from the client portal and until cancellation fees are paid, your appointment will not be reinstated. If you are removed from the regular schedule because of missed appointments, there is no guarantee that your appointment time will be available. Please note: ***insurance does not pay for missed appointments.***

You will be charged for any additional services you request of Lori Kimmerly Therapy outside of your appointment time. Any time spent testifying in court will be charged at $100.00 per hour, including travel time.

- Legal and Court Circumstances: If you are involved in a court proceeding and a request is made for information concerning the professional services we provided you, such information is protected by the therapist-patient privilege law. We cannot provide any information without 1) your written authorization; 2) a subpoena of which you have been properly notified, and you have failed to inform me that you are opposing the subpoena; or 3) a court order requiring the disclosure. If you are involved in or contemplating litigation, you should consult with your attorney about likely required court disclosures.

Insurance
Your insurance may cover a part of the cost of therapy. If you wish to use your insurance, I will bill your insurance company directly. If I am not in-network with your insurance company, you will be responsible for any difference between what I charge and what your insurance company pays for the service. By signing this agreement you are giving Lori Kimmerly Therapy authorization to bill your insurance.

- Insurance Reimbursement: If you are choosing to use benefits provided by an insurance company, I will be required to submit information to that company in order to obtain reimbursement or authorization of services. This document serves aa a release for this purpose to bill your insurance. You should also be aware that your contract with your health insurance company requires that I provide it with information relevant to the services that I provide to you. I am required to provide a clinical diagnosis. Sometimes I am required to provide additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record. In such situations, I will make ever effort to release only the minimum information about you that is necessary. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit, if you request it. By signing this Agreement, you agree that I can provide requested information to your insurance carrier.

  Please discuss any concerns or questions you may have regarding these exceptions to confidentiality.

Confidentiality
No information about you is released by me to anyone without your written permission, except as required by law (see above). I am required by law to report suspected child abuse (regardless of when it occurred), elder abuse, and clear and concrete evidence of planned acts of violence. *See my Notice of Privacy Practices and Washington Required Disclosure Form for additional details.*

Written Records
I maintain written files about your service for five (5) years. You have the right to review your file. If so desired, please arrange such a review with me.

Grievance
If you have any concerns or complaints about your therapy, address the issue directly with me. If the issue is not resolved to your satisfaction, feel free to direct your concerns in writing to Lori Kimmerly, MS LMFT

I/We, the undersigned, certify that I have read and understand my rights and responsibilities as outlined in this document. I understand that if I leave therapy with an unpaid balance, I will make every effort to collect these debts. Any attorney fees or costs resulting from my collection efforts will be an additional charge to my balance owing. I understand my obligations under this agreement, and fully agree to pay for my service at my established rate. I do hereby request and consent to treatment by (Lori Kimmerly LMFT, Lori Kimmerly Therapy and Coaching, PLLC). I will participate in the development of a treatment plan that best addresses my needs or situation. I understand that nothing in this Service Agreement shall be interpreted to limit or modify my rights and obligations under the State required Disclosure Form or my Notice of Privacy Practices.

Child Consent
I/We the undersigned parents (or legal guardians) of ______________________________________, do hereby request and consent to the treatment of our child by (Therapist's name). We understand we will participate in the development of a treatment plan that best addresses his/her needs or situation.

Client's Signature____Date__________________________

Client's Signature____Date__________________________

Therapist's Signature____Date__________________________