LEONA FURNARI, L.C.S.W.

Licensed Clinical Social Worker
1137 Pearl Street, Suite #208
Boulder, Colorado 80302
303-444-0992

Therapy Policies and Contract

I encourage you to be an active partner with me in your psychotherapy. Please bring up any questions or concerns you may have so that we can work together effectively. You may seek a second opinion if you wish and you may end treatment at any time.

FINANCIAL AGREEMENT

My fees are $145.00 for a 50-minute session and $185.00 for a 75-minute session. **Payment is to be at the beginning of each session**. Fees paid by check or cash at the time of service, or in advance, will have a $15 discount/session. In order to keep fees down I do not bill on a monthly basis. _____

I am not in-network with any insurance companies. If you would like a monthly statement to submit to your insurance company for out-of-network benefits **please let me know on a monthly basis** and I will provide this.

I do not generally charge for occasional, brief phone contacts between sessions with you, or with other professionals on your behalf. If such contacts become frequent or extended I will charge a pro-rated fee based on my regular rates. I will discuss this with you in advance. I charge my usual fee (pro-rated) for other professional services I may provide to you. These services include (though are not limited to) report writing, attendance at meetings with other professionals you have authorized, preparation of record or treatment summaries.

CANCELLATION

Please notify me by telephone (303-444-0992) at least 36 hours in advance if you need to cancel or reschedule an appointment. Without such notice you will be charged your regular session fee for the missed appointment. I do not accept text or e-mail cancellations at this time. _____

OTHER IMPORTANT INFORMATION

1. During my vacations or absences from my practice, I will designate a backup therapist(s) to cover urgent matters. Generally, I will tell this therapist only what he or she needs to know for an emergency. You will be responsible to pay this therapist her or his stated fee.
2. I may seek consultation from another mental health professional(s). However, your identity will not be revealed without your consent, and your privacy will be protected by that professional.
3. **I do not communicate by email or text with clients, and all appointments are made via my office phone/voicemail at 303-444-0992. _____**

Therapy Policies and Contract (continued)

Exceptions to confidentiality include those stated in Disclosure Statement, and:
1. Your name and address may be sent to a collection agency if I am unable to collect my agreed upon fee.
2. Your right to confidentiality will be waived if you file an official complaint or a lawsuit against me.

RECORDS
Records can only be released with your written permission, and if you were seen in couple or family sessions, all adults present would have to sign the release. It is my policy to not release an entire record, even with your consent. Instead, I will summarize the content related to the request. If you choose to read your record, it is my policy to be present in order to respond to any questions or confusion you may have about the records. _____

LEGAL PROCEEDINGS
If you ever become involved in custody or other legal proceedings, I do not provide evaluations or expert testimony in court. You should hire a different mental health professional for any evaluations or testimony you require. This position is based on two reasons: (1) My statements will be seen as biased in your favor because we have had a therapy relationship, and (2) The testimony might affect our therapy relationship, and I must put this relationship first. For any legal preparation my fee is $350/hour. _____

TERMINATION
Termination will usually be agreed upon mutually, but you are free to terminate at any time. However, in a few special instances I may decide to stop working with you even though you wish to continue. These include a failure to meet the terms of our fee agreement, a need for special services outside of the area of my competency, and prolonged inability to make progress in our work together. Should this occur, the reason for termination will be discussed with you, and you will be encouraged to make different plans for yourself, including a referral to more appropriate resources.

I have read and understand the Therapy Policies & Contract. I consent to therapeutic services from Leona Furnari, LCSW, and agree to meet the financial obligations. I give permission for information to be released, as needed, for consultation or fee collection.

______________________________ ______________________________

Client Name/Guardian for Minor (print) Client Signature/Guardian for Minor date

Leona Furnari, LCSW ______________________________

Therapist Name Therapist Signature date