

Alan Swindall, M.A., M.Div.
Licensed Marriage and Family Therapist
PO Box 220
Alabaster, Alabama 35007
Phone (205) 668-2344

COUNSELING SERVICES AGREEMENT

A counseling relationship is hereby entered into by Alan Swindall, Licensed Marriage & Family Therapist, and the following clients:

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1. All information disclosed, verbalized, or otherwise presented by the client(s) will be held in confidence by the counselor, except in the extreme and unusual circumstance in which failure to disclose information by the counselor would violate Alabama law and/or likely result in harm to the client(s) or to other members of society, or except in the case of written consent by the client(s) for disclosure of information.
 2. The counselor in this relationship is a trained, experienced, and licensed marriage and family therapist. However, the counselor cannot guarantee change in the behavior, or emotional state of those with whom he counsels, nor can the counselor promise the client(s) that all problems will be resolved.
 3. There may be risks involved in entering a counseling relationship. For example, a client who seeks counseling regarding an unfilled relationship may decide, after discussing all solutions to the problem, to terminate the relationship.
 4. This counseling relationship may consist of talking, role-playing, listening, and learning new modes of self-expression, values clarification, behavior modification exercises, and/or "homework" assignments.
 5. The office phone is answered either in person or by an answering machine 24 hours a day. Should you need to reach your counselor for emergency assistance and the call is answered by the answering machine, you may listen to the outgoing message for instructions. Extensive or frequent phone calls may be counted as sessions, and payment will be charged for these calls.
 6. Each session will be counted as one visit. If you are late, that time is lost from your session. Every effort will be made by the provider to see you at the scheduled time. However, if the therapist is late for a session, he will extend the session if you are willing to do so, or will make other arrangements by mutual agreement.
 7. The fee for counseling services is \$120.00 per session. The fee is due at the end of the session, and may be paid by cash or check, payable to the order of Alan Swindall, LMFT. The fee for future sessions can be negotiated with the counselor if necessary. If you file an insurance claim, please have the insurance company reimburse you.

8. Cancellation Policy: Since a regular time-slot has been reserved for your appointment, it cannot be offered to anyone else. There will be no charge for cancellation of appointment at least 24 hours in advance. Half fee will be charged for cancellation with less than 24-hour notice. The full fee will be charged for an appointment missed without notification.
9. Forensic services will be billed at the rate of \$120.00 per hour. This charge applies to time for preparation and court appearance.
10. You will be responsible for all court costs, attorney fees, and any other fees associated with the collection of this account, if this account is presented to an agency for collection.
11. If a minor under fourteen (14) years of age who has never been married, has not graduated from high school, and is not pregnant or borne a child, I, being a legally recognized parent/s* will be the legal party to sign this Counseling Services Agreement. Accordingly, I shall be fully informed about all matters germane to the child's treatment and hereby agree to be responsible for payment of all services.

***NOTE: "Legally recognized parent" is defined as the primary custodial parent as stipulated by law. Non-custodial parents (e.g. as defined by the court) may not independently seek psychotherapy or evaluation unless the primary custodial parent consents, or unless the court pre-certifies (e.g. per order) treatment or evaluation of the minor (under age 18) patient.**

I have read the preceding and consent to the conditions and by my signature acknowledge that I have received the Notice of Privacy Practices.

Date: _____

Client: _____

Client: _____

Counselor: _____