Constance Anne Klein, LCSW
Tree of Life Psychotherapy LLC
1705 S. Pearl Street Suite 6
Denver CO 80210
720.261.4459

CONTRACT FOR PSYCHOTHERAPY

Trust and open, clear communication are essential elements of effective psychotherapy. This contract is intended to minimize the possibility of later misunderstandings by setting out at the beginning of our relationship the policies by which I run my practice. Your signature below indicates that you have read and understood these policies and are agreeing to abide by them. If questions or concerns regarding these policies arise at any point in the therapy process, please bring them up with me.

FINANCIAL ARRANGEMENTS: My standard fee for psychotherapy is $140 for a 60 minute outpatient session. I typically charge on a pro-rated basis for such activities as preparation of written reports, non-routine phone calls, consultation with lawyers or other professionals, and direct consultation with parents. **Payment of service fees or copayments is due at the time of service unless other arrangements have been made.** Payment can be made by credit cards (VISA, Mastercard, or Discover), check, or cash. Credit card payments can be made directly with my office. My office uses a password-protected encrypted service to process those payments. If you wish to pay with a credit card kept on file, please complete the Payment Form with this office.

I am not an in-network provider for any insurance plans. I am happy to provide regular statements directly to you to submit for out-of-network payment when that applies. All service fees are due at the time of service. Check, cash or credit cards (VISA, MasterCard, and Discover) are accepted via an encrypted, password-protected service. If you wish to pay with a credit card kept on file, please complete and print the Payment Form. To ensure that everyone has access to services, I offer a **Sliding Scale** to individuals and families who meet eligibility requirements. Please feel free to ask for that information.

The client, or the referring parent or guardian in the case of a minor, bears final and full responsibility to see to it that all professional fees are completely paid. Please feel free to discuss financial arrangements or concerns with me at any tme. I would much prefer to talk about potential problems rather than let a burdensome balance build up.

MISSED APPOINTMENTS: When a therapy appointment is set up, I reserve that time for you. If you have to change or cancel an appointment, please give me at least **48 hours advance notice**. I will charge for any missed or cancelled sessions when this notice has not been given. **A fee of $100 will be charged for a missed visit or late cancellation.**

COLLECTION: I reserve the right to use a collection agency or to take legal action if there is not an effort to pay off all or a portion of any outstanding balance. Under these circumstances, I may need to reveal your name, address, telephone number, place of employment, and other pertinent information to the court or collection agency. I will disclose only information

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necessary for the collection process; all other information will be treated with the utmost confidentiality.

Your signature below indicates that you have read and understood the preceding information and agree to abide by the provisions of this contract.

_____ _____
Signature of Client or Parent/Guardian Date

_____ _____
Constance Anne Klein, LCSW Date