

# MOVING MINDS FORWARD LLC.

## PRACTICE INFORMATION AND AGREEMENT FOR SERVICES

Welcome to therapy. I look forward to collaborating with you on this journey. Please carefully read the information below and initial to the right of each paragraph. Sign and date this agreement at the conclusion. Please retain a copy of this for your records. If you have any questions, let me know and we can discuss them during our initial session together. ***Your initials and signature indicate you have read this information, understand it, and agree to the terms identified herein.***

Sessions are by appointment only and run 50 minutes unless otherwise scheduled. I cannot guarantee online tele-health services as 100% confidential but take every precaution to protect your confidentiality. \_\_\_\_\_

### **Canceling or Rescheduling Appointments**

If you need to cancel or reschedule an appointment, please send a text or leave a voicemail on my office line 24 business hours prior to your scheduled appointment or you will be charged a \$50.00 no show fee. If you cancel on Sunday for a Monday appointment, you will be charged the identified fee. In situations of illness or extreme weather (tornadoes), you will not be charged. \_\_\_\_\_

### **Contacting Me**

You may reach me at 314-474-7516. Please leave your name, message and phone number, and I will return your call as soon as I am available. All calls over the weekend or during holidays will be returned on the next business day. \_\_\_\_\_

Text and Email communication:

My email address is michael@movingmindsforwardllc.com.

Text and email correspondence are acceptable for giving cancellation notice or updating/confirming an appointment. I will not give advice or comment on therapeutic situations via email or text. I check email and text twice daily Monday-Friday from 9am to 5pm. Emails sent to me during evenings, holidays or weekends will be answered on the next business day. \_\_\_\_\_

### **Emergencies**

If you have an urgent situation and need to notify me after hours, you are welcome to do so via email or text. As indicated above, that correspondence will be answered until the next business day. If you have a dangerous or life-threatening situation, call 911 or contact The Behavioral Health Response Hotline at 800-811-4760. \_\_\_\_\_

### **Fees**

Session fees associated with private pay and access of out of network benefits will be collected at the start of each session. My fee for a 50-minute session is \$135.00. Fees are collected using debit or credit cards as well as check or cash (exact change is necessary). This fee will apply to work requested out of sessions, which could include meetings with schools, consultation with other members of your treatment team, etc. which exceeds 15 minutes.

If you are in therapy with me or have terminated therapy with me, and I am legally ordered to become involved in calls with attorneys, guardian ad litem, police, or any court appointed representatives, to submit records, provide testimony, or appear in court, my fee for these services remains the same for all time (including travel) in these matters. This fee applies whether you are the one initiating the legal proceeding or not. \_\_\_\_\_

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**Insurance**

My ability to work with selected insurance companies is currently pending and am only accepting private pay and clients utilizing their out of network benefits. All clients automatically receive a monthly insurance-ready statement to submit to your insurance company that will have all the information they need to process your out of network claim. \_\_\_\_\_

**Confidentiality**

All information that you share with me in session – in person or virtually, by phone or in writing (including Emails and texts) is strictly confidential and cannot be shared by me with anyone without your expressed permission, excluding the following:

1. Child abuse – If I have reasonable cause to suspect that a child has been or may be subjected to abuse or neglect, or if I observe a child being subjected to conditions which could reasonably result in abuse or neglect, or sexual abuse, I am legally mandated to report such information to the Missouri Division of Family Services. \_\_\_\_\_
2. General abuse – If I have reasonable cause to suspect that an eligible adult presents a likelihood of suffering from physical harm or is in need of protective services, I am legally mandated to report this to the MO Department of Social Services. “Eligible adult” means any person 60 years of age or older, or an adult with a handicap (substantially limited mental or physical impairment) between the ages of 18 and 59 years old who is unable to protect his/her own interests or adequately perform or obtain services necessary to meet his/her essential human needs. \_\_\_\_\_
3. Risk of serious threat to health or safety of self or others - Should I judge that disclosure is necessary to protect against a clear risk of imminent serious harm being inflicted on you by yourself or someone else inflicting harm on you, or by yourself inflicting harm on another person, I must disclose your relevant confidential information to the appropriate professional workers, police, public authorities, the potential victim, his or her family, or your family. \_\_\_\_\_
4. When I judge it appropriate therapeutically, I reserve the right to consult with professional colleagues. In these consultations, your name will not be used. \_\_\_\_\_

I look forward to being helpful to you and thank you for giving me this opportunity to be of service. Your signature below indicates that you have read this agreement, understand it, and agree to its terms.

Client(s) signature (Date)

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Parent/guardian signature (Date)

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