Kara Smith, LCSW
EMDR & Psychotherapy

2990 Richmond Ave
Suite 630
Houston, TX 77098

281-410-1593 (phone/text)
karasmithlcsw@gmail.com
713-583-8838 (secure fax)

STANDARD FEE FOR SERVICES & FEE AGREEMENT

I understand that the standard fee for services for individual psychotherapy is $125.00-$175.00 per 45-50 minute session and $220.00-$310.00 per 80 minute EMDR reprocessing session. I further understand that unless another payment schedule is specifically arranged, the standard fee for services applies. Any revisions to these standard fees for services are indicated on the reverse.

I understand that if I am in a position to pay the standard fee for services, I will do so. I also understand that if my situation changes at any point that I am invited to re-negotiate this fee with my therapist.

PAYMENT AGREEMENT

I understand that I, _____, will pay for all services provided at the time each session is rendered.

I understand that I may pay with cash, personal checks, or credit card. Should my personal check be returned due to insufficient funds, I will be assessed a $50.00 service charge and I will be requested to pay with cash or credit card thereafter. I realize that while my signature does not bind me to therapy, it does make me responsible for all charges incurred prior to my termination.

I understand that if I am not able to honor my financial commitment that this may be grounds for conversing therapeutically about financial issues, renegotiating my therapeutic contract, exploring alternative options, and/or terminating from treatment. I further understand that if I am not able to make a payment after a particular session that I may ask my therapist for an extension for another week. I agree to make every effort to remit payment within that time frame. *I also understand that I may not have more than two unpaid sessions accumulated at any one time.*

MISSED SESSION POLICY

I understand that unless otherwise indicated, I will be charged $125-310 for any missed sessions or sessions canceled with less than 24 hours' notice. Emergency circumstances are discussed on an individual basis.

LIMITATIONS OF CONFIDENTIALITY

I understand that if another party, such as an insurance company, is providing reimbursement for my therapeutic services, I authorize that individual or institution to be informed of my presence in treatment, details of my diagnoses and care, and/or my discharge from treatment. I also understand that there are further limitations to confidentiality discussed in the Notice of Privacy Practices or other agreements and am aware of these constraints.

USING INSURANCE OR THIRD-PARTY PAYMENT SOURCES

I understand that in general, Kara Smith, LCSW encourages me to be personally responsible for paying my fees at the time of service. In so doing, I recognize that I am actively participating and investing in the therapeutic process and am able to maintain a direct relationship with this investment. In addition, I understand that this type of arrangement ensures my confidentiality and further allows me and Kara Smith, LCSW to make decisions about the care in my best interest. At the same time, I understand that Kara Smith, LCSW recognizes that I may wish to use an out-of-network insurance plan. I will be able to request an invoice for the services I have received and the payments I have made so that I may submit these to my insurance company for reimbursement. I further understand that Kara Smith, LCSW may work with me and other third-party payment sources to enhance my access to these services and that such circumstances will be evaluated individually as they arise.

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If I should choose to use a third-party payment source, I understand that I am still responsible for direct payment to Kara Smith, LCSW and that no guarantees can be made in terms of my reimbursement by the third party payment source. However, Kara Smith, LCSW will work with me as much as possible to facilitate this process.

I understand that if I use insurance or another type of third-party payment source that I authorize Kara Smith, LCSW to release and/or exchange any pertinent information with such entities in order to utilize these benefits. This information includes but is not limited to my presence in treatment, my progress in treatment, my psychiatric diagnosis, any assessment information, and my discharge plan. **I understand that most third-party payment sources, such as insurance companies, do not pay for missed sessions and thus I am solely responsible for these fees.**

FEE SCHEDULE ADJUSTMENTS

The following reflects the adjusted fee schedule I have made with my therapist based on a therapeutic conversation about these services and my present life situation:

$ **125-175** Fee per 45-50 minute Individual Psychotherapy session or 50 minute Couples Therapy session

$ **220-310** Fee for an extended, 80-minute EMDR reprocessing session (optional)

$ **125-310** Fee for canceling with less than 24 hours advanced notice

$ **125-310** Fee for not showing up within 15 minutes of the scheduled appointment time.
A text message reminder will be sent to you 5 minutes after your scheduled appointment time.

I have read the preceding information and I agree to the aforementioned terms.

Client Name | Client Signature | Date

Kara Smith, LCSW

Therapist Name | *Therapist Signature* | *Date*

□ Copy accepted by client □ Copy kept by therapist

This is a strictly confidential patient medical record. Redisclosure and/or transfer are expressly prohibited by law.