



# MOTIVATE Counseling & Coaching

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Client's Name: \_\_\_\_\_

## POLICIES AND PROCEDURES

Thank you for selecting **MOTIVATE Counseling & Coaching** as your mental health and coaching practice! Please read the following *Policies and Procedures* carefully and in full. Email or call with any questions, concerns, and/or clarification needs. Initial each page in the lower right-hand corner and be sure to sign the attestation section. When completed, please return all pages and you will be provided a copy for your reference. Thank you!

### SESSIONS AND FEES

The fee for an initial assessment is \$175.00 (50-60 minutes). The fee for an individual counseling or coaching session is \$150.00. The fee for a couples or family counseling session is \$175.00. If this practice is "in-network" with your insurance or EAP, it is possible subscribers are offered a reduced fee for service. Please advise the practice of your plans to use insurance or EAP authorization before your first appointment.

The initial assessment is used as a time for you to describe the issues you would like to address and to provide a bio/psycho/social history. The clinician will use this initial appointment to assess needs and if he/she can be of assistance to you. At the end of the assessment, you and the clinician will decide together if and how to proceed.

After beginning treatment, if the clinician is unable to contact you for a period of 60 days from the last session, you will no longer be considered an active or current patient. You may contact the practice to discuss resuming therapy.

There is no charge for brief routine phone calls; however, telephone calls or other activities related or in addition to the services being rendered will be charged exclusively to the client. Such charges will be in 15-minute increments based on length of time involved and at the rate consistent with the services typically rendered (i.e. individual, family, or couples).

Other activities undertaken on your behalf during or after treatment will be charged to the client at the same rate as above. This may include but is not limited to disability determination reports, vocational rehabilitation reports, DSS interaction, consultations with another professional at your request, or any other request **not** related to acute psychiatric care or continuity of care (i.e. transfer of your care to another clinician). The clinician will not be able to engage in any such *elective* activities on your behalf if you have a past due balance. These policies apply to all clients.

**MOTIVATE Counseling & Coaching** does not charge to send records in continuity of care situations.

Record copying fees are set by General Statute §90-411: *"To cover the costs incurred in searching, handling and copying medical records, a fee for each request shall be seventy-five cents per page for the first 25 pages, fifty cents per page for pages 26 through 100 and twenty-five cents for each page in excess of 100 pages and a minimum fee of up to ten dollars, inclusive of copying costs, for mailing medical records for the patient or the patient's designated representative. If requested by the patient or the patient's designated representative, nothing herein shall limit a reasonable professional fee charged by a physician for the review and preparation of a narrative summary of the patient's medical record."*

## **PAYMENTS & INSURANCE**

Payment for services is due at the time of service. **Clients will be required to have a credit or debit card on file.** If utilizing your health insurance's "out-of-network" benefits, full payment is due and this practice will provide all needed documentation for you to submit for reimbursement. In cases where this practice is an "in-network" provider with your health insurance, payment would include any co-payment or unmet deductible.

If "in-network" with your health insurance, **MOTIVATE Counseling & Coaching** will file and accept payment directly from your insurance company as a courtesy to clients. However, please note that you are ultimately responsible for all charges incurred for your treatment or the treatment of those for whom you are responsible. If, for any reason, your insurance company does not remit payment within forty-five (45) days of your appointment, the amount is then due by you. If they eventually make payment, you will be reimbursed. Please review the EOBs sent by your insurance company in order to be certain they are paying for your services in a timely manner. It is the client's responsibility to deal with their insurance company if any delays, errors, or other problems occur with authorizations, claim payment, etc.

For minor clients, the person in physical custody will be responsible for any psychotherapy or coaching fees regardless of who is legally liable. This practice will provide a statement and you may collect from the responsible parent.

## **BILLING**

By law, any contracts with insurance providers require that this practice collect co-payments and deductible amounts from subscribers. Accounts with a past due balance of 30 days or more will be assessed an interest charge of 1.5% monthly on the past due balance, as well as a \$5.00 monthly billing fee. Checks not honored by the bank will be subject to a Returned Check Fee of \$50.00. Delinquent accounts may be turned over to legal or collections services at the expense of the client including but not limited to attorney and/or collection company fees. Services may be discontinued for clients who do not uphold their contract for fee payment.

## **CONFIDENTIALITY**

A statement of your rights, the **Notice of Privacy Practices**, will be made available to you and a copy is posted in the office. Client/clinician communications are confidential. There are some exceptions that will be reviewed with you in the **Limits of Confidentiality**. These exceptions include risk of harm to self or others, disclosures of abuse to minors, individuals with disabilities, and the elderly, or prenatal exposure to controlled substances. As a Licensed Clinical Social Worker, I am professionally bound by confidentiality and mandated reporting regulations. During professional conversations, clinicians may consult with colleagues when beneficial to the client in a discreet and confidential manner. If you have any questions, concerns, or need clarification, please make the clinician aware.

## **CLIENT RIGHTS**

You have the right to be treated with dignity and respect. All services are voluntary and you have the right to refuse any service. By signing these **Policies and Procedures**, you are giving informed consent for **MOTIVATE Counseling & Coaching** to provide services. You understand that there is no guarantee regarding the outcome of these services. You also understand that while the goal is to resolve the issues that you describe to the clinician, there is no guarantee they will be resolved. You understand that the clinician cannot know what you do not tell them. There are no known harms as a result of therapy; however, sometimes the process of therapy or similar services can be uncomfortable as challenging, difficult, or painful issues are addressed. It is important to advise the clinician if this becomes unmanageable for you.

Please refer to this **Policies and Procedures** document as a guide and speak with your clinician directly for any questions or concerns regarding services. Such matters can typically be resolved collaboratively and provide a growth opportunity for both the client and clinician. There is absolutely no retribution, negative sanction, or reprisal for expressing complaints using this protocol.

## **LEGAL TESTIMONY**

Counseling or other such services need to be a place where one can openly and with trust, be candid about the issues they hope to address. Requesting that your clinician change roles from supportive, non-judgmental facilitator to becoming involved in litigation or other legal proceedings is often contraindicated to treatment, and therefore, your

clinician will NOT provide courtroom testimony during or after treatment has terminated. In situations where preparation for litigation is the stated reason for seeking services, this practice can assist you by referral. If you know or anticipate that you may need mental health expertise due to planned or expected litigation, please advise me now.

If, for any reason, you involve this practice in any legal matters (including but not limited to courtroom testimony, consultations with an attorney, letter or report writing, travel, and preparation) during or after treatment has ended, the fee for any services rendered will be \$175.00 per hour. **This practice does not participate in 'telephone standby' arrangements; therefore, if subpoenaed to court, time is billed in four (4) and eight (8) hour increments, regardless of the actual time spent. This includes any anticipated time for preparation and travel. All fees related to litigation must be paid prior to release of any information or court appearance. It is your responsibility to advise your attorney that you have agreed to this policy.**

### **CANCELLATION POLICY**

There is no charge for appointments cancelled more than twenty-four (24) hours in advance. **Practices cannot bill insurance or recoup the lost time slot and income for missed appointments or late cancellations;** therefore, clients will be billed the full cost of the session for any appointments missed or cancelled less than 24 hours in advance. **A full 24-hour notice is required to avoid a charge.** In order to be fair to all parties, **no exceptions are made to this policy.** Because the charge is based on the fact that the time was reserved for you, your reason for canceling, however valid it may be, does not affect this policy. Two (2) late cancellations or no shows within a 3-month period may result in a termination from services.

Appointments missed or cancelled late will be billed to the client on the date of service. If you miss or cancel an appointment late, you will need to handle any fees incurred from the missed appointment before any future appointments can be scheduled with this practice. In the event you have previously scheduled appointments, those appointments may be cancelled if the account is not settled within five (5) business days from the missed or late cancelled appointment. No show and late cancellation fees not paid within 30 days may be subject to an interest charge of 1.5% monthly and a \$5.00 monthly billing fee.

If you are going to be more than 15 minutes late for your appointment, please contact the practice and let the clinician know you will be keeping the appointment but arriving late. The practice will also attempt to reach you in the event that the clinician is running behind schedule.

### **INCLEMENT WEATHER**

In the event of inclement weather, please contact the office. Status and cancellation policy during the inclement weather event will be available.

### **EMERGENCIES**

**MOTIVATE Counseling & Coaching does not provide emergency services.** Many times, situations occur that are upsetting or unsettling, but not life threatening. For these situations, please schedule an appointment. Consultation calls under these circumstances will be billed as previously noted.

In the event of a life-threatening emergency (suicide/homicide) where thoughts or impulses cannot be safely managed or where there is reason to believe an individual has access to lethal means, lethal means are in hand, or have been used, immediate medical attention or law enforcement intervention is required. **YOU ARE TO CALL 911** and communicate the nature of the life-threatening emergency. As soon as possible after this, please contact the clinician and leave a message with the client's location so that appropriate follow-up may be coordinated.

Mental health service providers can neither predict nor foresee acts of suicide or homicide. If you (or the child/dependent you are seeking services for) are currently experiencing suicidal and/or homicidal thoughts, or such thoughts develop while an active client with this practice, you are to inform the clinician immediately.

**ATTESTATION:** I have read, understand and agree to the above Policies and Procedures. I have been given an opportunity to ask questions and have been provided a copy of this information. I understand that by signing this page, I am accepting and agreeing to all policies and procedures and acknowledging my responsibilities noted herein. These Policies and Procedures supersede all others.

\_\_\_\_\_  
Signature of Client (Or parent/legal guardian if applicable) Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

\_\_\_\_\_  
Please Print Name Relationship (write "Self" if client)

**HIPAA AND STATEMENT OF CLIENT RIGHTS ACKNOWLEDGEMENT:** I acknowledge that I have been given the opportunity to receive a copy of the **Notice of Privacy Practices** and the **Statement of Client Rights** to read, and acknowledge that they are posted in the office. I further understand that I will be furnished a copy upon request.

\_\_\_\_\_  
Signature of Client (Or parent/legal guardian if applicable) Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_