Tina Champagne OTD OTR/L for Cutchins Care LLC

Terms of Agreement for Psychotherapy and Neurotherapy Services

Payment and co-payment: All fees are due at each session. By agreement, payment may be made once a week or every other session, preferably at the start of the week. If you are engaged in neurotherapy and psychotherapy, payment includes a neurotherapy session fee and any applicable co-pay.

When scheduling sessions that include psychotherapy and neurotherapy, the agreed upon fees cover the extended time period of the session even in the event that, by agreement of both parties, neurotherapy is not part of a particular session.

Cancellation: Whenever possible please give at least 24 hour notice of cancelation. This notice allows vacated sessions to be filled when possible. With less than 24 hour notice there is a 25.00 cancellation fee if we are unable to reschedule the cancelled session within the same week. The 25.00 fee is applicable in all events except extreme weather.

I realize unforeseen events such as illness or car problems are outside of anyone's control. The 25.00 fee is not intended punitively. It is in place to offset loss of the session fee due to your absence and allows me to keep my overall fees as low as possible. Two week notice is requested when decreasing or ending weekly sessions.

In cases of frequent cancellations I reserve the right to request full payment for the missed sessions. This would always be discussed ahead with full explanation of why I am requesting the change.

Phone Contact: I attempt to return calls within 24 to 48 hours during the week. There are occasions when this is not possible. If your message is urgent please communicate this clearly when leaving it and I will do my best to respond quickly. In the case of a psychiatric emergency, please contact Emergency Services for Hampshire County at 413-586-5555, or your local emergency room.

Confidentiality: All patient information is confidential. The exceptions to this agreement is as mandated by law. The exceptions are: the report of actual or possible abuse of a child or elder over the age of 65, serious risk of harm to self or another, or authorization by you to release information to an agreed upon third party.

I appreciate your commitment to this agreement. The parameters included support my ability to offer a high level of care with a full and sincere focus on your treatment goals.

Client Signature _____ **Date** _____

Ellen Shaw-Smith, LICSW, BCN
104 Russell St. Hadley, MA 01035
Phone 413-582-0355 Fax 413-582-0411

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