Mercy Professional Services Inc, 1015 South Compton Ave. St. Louis MO. 63104

therapy agreement

I grant permission for psychotherapy services for myself/my relationship / my family. I understand that **Michelle Salois, RN, LCSW** is a Licensed Clinical Social Worker committed to applicable ethical codes and subject to State and Federal laws for the practice of Clinical Social Workers. I have agreed to an hourly (45-50 minutes) fee of $150 for first and family sessions. or $120 for individual sessions (or rate contracted with my Third Party Payor) with Client Responsibility of $ _____
my Copay is $_____

B) I agree to give at least **24 hour notice of cancellation** of an appointment and understand that I (not my insurance company) am responsible for the **full fee** if I fail to give this notice.

C) I acknowledge that I have been given notice of the Privacy Policies and Practices of Mercy Professional services. (Here are **key points** as a reminder: All our communication, and the fact that I and/or my loved ones are receiving counseling here is confidential information which may be used only in the process of treatment, payment and operations. Exceptions to this confidentiality may arise in case of danger of death or serious harm to myself or another, a court order or, in accord with state laws to protect a child or "dependent adult".

D) I understand that Michelle Salois may contact the person who referred me to her to thank that person and let them know I came, but that I may prevent this by a written or verbal refusal.

X_____
Signature of client(s) or guardian *Date*

If this acknowledgment is signed by a personal representative on behalf of the client complete the following:
Personal Representative's Name PRINT:_____
Relationship to Client: _____

(Sign here if you want your services paid for by insurance) I authorize the release to my insurance company and/or my managed care company or their designated agents of any information necessary to obtain authorization for treatment and process my claims for third party reimbursement. I understand that this release may be revoked at any time except to the extent that action has been taken in reliance upon it. If I do not revoke it, this consent will expire one (1) year after I have terminated treatment and payment has been made or claim has been settled with my Therapist. I remain responsible for the payment of my account. I authorize assignment of benefit payments directly to Mercy Professional Services
Signature(s)X_____

FOR OFFICE USE ONLY

I attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:
Individual refused to sign
Communications barriers prohibited obtaining the acknowledgment
An emergency situation prevented us from obtaining acknowledgment
Other (please specify)_____

This form will be retained in your medical Record