Linda Piantieri, MA, NCC
Licensed Marriage & Family Therapist
Licensed Mental Health Counselor, www.lindapiantieri.com
1850 Lee Road, Suite 212, Winter Park, FL 32789 phone: 407-719-2525

Counseling Agreement

You have made an important decision. In an effort to promote a trusted and productive counseling relationship, the following information is provided for your understanding and consent.

Counseling is sometimes an intense but rewarding experience. Clients are in charge of their own experience and are encouraged to work in a collaborative relationship towards the resolution of mutually agreed upon goals. Clients will work with Linda Piantieri to determine the best setting to address the identified areas of concern (via individual, marital or family therapy sessions).

Confidentiality

Your care and all counseling sessions are completely confidential. This has been deemed so essential to the counseling relationship that a breech of your right to confidentiality by a therapist is both unethical and illegal. Your private information will not be discussed with anyone unless all the parties involved in the counseling sessions agree in writing to such disclosures. There are a few circumstances when I am required to breech your confidence. They are as follows:

1. If I believe you or another person is in imminent danger I may need to take action to protect an individual's life that I feel may be in danger. This may include contacting law enforcement, a hospital, family member or the intended victim.
2. If abuse or neglect of a child, elderly person, or disabled person is suspected, I am required by law to report any pertinent information to the appropriate division of law enforcement or the Department of Children and Family Services.
3. If I receive a legally binding Court order for records, deposition or testimony, I am required to comply.

In addition, if you are using your insurance as a form of payment or reimbursement I am required to provide them with information they may need to make decisions about continued care or payment.

In order to ensure the best possible care is provided, it is common practice and my policy to consult with other mental health professionals. In these instances, identifying information is kept to a minimum and confidentiality extends to other professionals collaterally consulted.

Fees

My fees are as follows;
90791: Initial assessment (50 minutes*) $175.00
90834: Individual Therapy (50 minutes*) $125.00; 90837: (70 minutes) $175.00
90846/47: Family Therapy (50 minutes*) $150.00; 70 minutes $210.00
* All times are plus or minus 7 minutes.

Payment is expected at the time services are rendered unless other arrangements are made.

Phone consultations are free up to 9 minutes and will be billed for calls in excess of 10 minutes. Phone consultation is at the above rate, per therapeutic hour (prorated), and can be paid at the following in-person session.

Written reports are $250.00/hour with a one-hour minimum.

Fees for court appearances include preparation and travel time and are billed at the rate of $250.00/hour. A $1,200.00 retainer is due up front and will be applied to any incurred court costs. Court costs are generally not reimbursable. Payment is expected at the time services are rendered unless other arrangements are made.

Appointments and Emergencies:
All appointments are scheduled. I do not see patients on a walk-in basis. If you are experiencing a crisis, I can be reached on my business line at (407) 719-2525. I can usually schedule crisis sessions within 24 hours. If you have a true emergency and you reach my voice mail system, please call the Life Care Center of Florida at (407) 425-2624 or call 911 or go directly to your nearest emergency room.

If you need to cancel a session or change your appointment please contact me as soon as possible. If this does not occur within 24 hours prior to your scheduled session you will be responsible for paying the entire session fee.

Consent for therapy
I have read and understand the information contained in this form and voluntarily agree to participate in the therapy process knowing that I can terminate the therapy or refuse treatment at any time.

_____ _____
Signature of Client Date

_____ _____
Signature of Client Date

_____ _____
Signature of parent or Guardian Date